STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 00 B. WING	04/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH NURSING HOME	701 S OAK STREET WINCHESTER, IN47394

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00087993. Complaint IN00087993 Substantiated, Federal/State Deficiencies related to the allegations are cited at F206 and F250. Survey dates: April 3, 4, 5, 6, 2011 Facility number: 000136 Provider number: 155231 AIM number: 100275450 Survey team: Ginger McNamee, R.N., TC Betty Retherford, R.N. Delinda Easterly, R.N. Karen Lewis, R.N. Census bed type: SNF/NF: 78 Total: 78 Census payor type: Medicare: 16 Medicaid: 39 Other: 23 Total: 78 Sample: 16	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Supplemental Sample: 1 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 4-12-11 Cathy Emswiller RN			
F0157	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in			

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	paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			
SS=G	Based on record review and interview, the facility failed to ensure the physician was promptly notified of the development of a fever and/or a change in sputum color resulting in hospitalization and treatment for sepsis, wound infection, and urinary tract infection for 1 of 1 resident with a tracheostomy reviewed for physician notification of a fever and respiratory complications in a sample of 16. (Resident #70) Findings include: 1. The clinical record for Resident #70 was reviewed on 4/3/11 at 4:00 p.m. Diagnoses for Resident #70 included, but were not limited to, history of aspiration pneumonia, chronic respiratory failure with status post tracheostomy, paraplegia, and diabetes mellitus. The clinical record indicated the resident received nutrition via a gastrostomy tube, had an anchored catheter, had a colostomy, and had a wound vac in place related to the surgical repair of a sacral decubitus. Admission orders, dated 3/25/11,	F0157	F157 Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by Randolph Nursing Home of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. **Please accept this plan of correction as our credible allegation of compliance with all regulatory requirements.** This facility informs the resident's physician of significant changes in resident condition. Corrective action for residents cited as affected Resident #70 Physician was notified and resident was sent to the Emergency Room for evaluation on 4-3-11 at 9:30 p.m. Identification of other residents at risk; All residents have the potential to be affected. Resident records were reviewed to assure physician notification regarding the development of fever or change in sputum color. Licensed nursing staff will use of Condition Change form for documentation of residents who have developed a fever and/or a	04/22/2011

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	indicated resident #70 was to receive humidification at 28% via tracheostomy (trach) and be given trach care every shift. An admission Minimum Data Set Assessment, dated 4/1/11, indicated Resident #70 was totally dependent on the staff for all activities of daily living and had a tracheostomy. A nursing note, dated 3/27/11 at 1:00 p.m., indicated Resident #70's lungs were clear and no signs and symptoms of infection were noted. The note indicated the resident's temperature was within normal limits. A nursing note, dated 3/28/11 at 7:35 p.m., indicated "... lungs with coarse crackles, productive cough noted at times, trach care given... small amount of thick yellow sputum noted...." A nursing note, dated 3/29/11 at 8:40 p.m., indicated "...lungs with bilateral crackles... suctioned times 3 this shift with large amounts of thick yellow sputum, inner canula changed times 2..." A nursing note, dated 3/30/11 at 4:00 p.m., indicated the resident had developed a temperature of 101.3 (type of temperature not noted) and Tylenol had been given. The note indicated "...lungs		change in sputum color in order to ensure timeliness of physician notification and interventions are in place for change in condition. (attachment A) All nursing staff will use form (attachment A) as an in-house tool for charting in nurses notes for all residents who have developed a fever and/or a change in sputum color in order to ensure timeliness of physician notification and interventions are in place for all change in conditions.Measures to ensure this deficient practice does not recur; Nursing staff will be re-inserviced as of April 22, 2011 to 1.) Change in Condition Monitoring log, 2.) Physician Notification Parameters and policy 3.) Process for physician notification including physician notification via facsimile and the process for situations requiring immediately informing a resident' s physician of a significant change in a resident condition. 4.) Documentation of change of condition and physician notification utilizing the Change in Condition Monitoring flow sheet and documentation of condition change on the 24 hour nursing report. (Attachment C) Nursing staff will use the condition change form, for documenting assessment of vital signs and physician notification for residents who have developed a fever and/or a change in sputum color, to ensure communication of physician notification and	

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	crackles in lower lobes...." A follow-up note at 8:00 p.m. indicated the resident's temperature was now 100.9 and Tylenol was given. A nursing note, dated 3/31/11 at 2:15 p.m., indicated the resident's temperature was 100.2. A nursing note, dated 4/1/11 at 4:30 a.m., indicated "...lungs diminished...trach care given with yellow thick sputum noted...." A nursing note, dated 4/2/11 at 10:30 p.m., indicated the resident had a temperature of 102.9 axillary and Tylenol was given. A follow up temperature taken at 12:30 a.m. on 4/3/11 was 101.7 axillary and the resident's respiratory rate was 20 breaths per minute. A nursing note, dated 4/3/11 at 10:30 a.m., indicated the resident's temperature was 102 and Tylenol was given. The resident's respiratory rate was 20 breaths per minute. A nursing note, dated 4/3/11 (a Sunday) at 3:00 p.m., indicated		intervention for fever or change in sputum color. (attachment A) The DON or designee will review the 24 hour daily report and review the change in condition monitoring log and nurses notes of residents noted to have experienced a change in condition, and assure appropriate physician notification of significant condition change. Monitoring of corrective action; The Director of Nursing or her designee will, each day, review the daily 24 hour report for resident change in condition and the change in condition monitoring form with the resident's medical chart to ensure nursing staff are appropriately notifying the resident's physician regarding a fever or change in sputum color. The Director of Nursing will monitor to assure appropriate physician notification through review of 24 hour report and new physician orders during the morning Interdisciplinary (IDT) meeting. This audit will occur 5x weekly for 30days, 3x weekly for 30 days 1x weekly for 90days in total. Findings will be reported to the QA&A team on a weekly basis to ensure timeliness of notification of a physician if a resident has developed a fever and/or a change in sputum color. These monitors will become part of Randolph Nursing Home's Quality Assurance program to assure all patients with a change in condition are reported and conveyed to the	

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	"Info to [name of doctor] office r/t (related to) current status." The nursing notes from 3/28/11 through 4/3/11 at 3:00 p.m. lacked any information related to the physician being notified of the resident's yellow sputum and/or elevated temperature prior to the info (information) being sent to the physician's office on Sunday 4/3/11 noted above. This indicated a time period of 6 days from the date the resident developed the thick yellow sputum which was later followed by the development of an elevated temperature and the physician was notified of these change in condition. The next nursing note was dated 4/3/11 at 8:00 p.m. and indicated "... [temperature]102.6 axillary. Coarse crackles heard in bilat (bilateral) lungs. Res [resident] coughing up dark yellow mucous...." The note indicated the resident's respiratory rate was 40 and his pulse was 134 beats per		physician timely. This review will continue on as part of Randolph Nursing Homes Quality Assurance Program.	

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	minute. The note indicated the resident's physician was paged at that time. A follow-up note at 9:00 p.m. indicated the physician was paged again. A nursing note, dated 4/3/11 at 9:30 p.m., indicated information on the resident's condition had been given to the physician and an order was received to send the resident to the emergency room for evaluation. A follow-up note at 10:00 p.m. indicated the resident had been taken from the facility via ambulance to the hospital. During an interview on 4/4/11 at 9:00 a.m., LPN #5 indicated Resident #70 had been sent to the hospital "last night" due to an elevated temperature and condition change and had been admitted for treatment. During an interview with the Director of Nursing on 4/6/11 at 10:50 a.m., indicated she had contacted the nurse at the hospital			

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	for information related to Resident #70's admission. She indicated the resident had been admitted with the diagnosis of possible sepsis with fevers and wound infection and a urinary tract infection had been noted after urine testing was completed. During an interview with the Director of Nursing and Administrator on 4/4/11 at 4:00 p.m., additional information was requested related to the delay in physician notification of the change in the resident's sputum and the development of an elevated temperature as noted above. The facility failed to provide any additional information as of exit on 4/6/11.			
SS=G	2.) Review of a current facility policy created 4/27/08, provided by the DoN on 4/4/11 at 4:35 p.m., titled "PHYSICIAN		F157 Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by Randolph Nursing Home of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and	04/22/2011

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	NOTIFICATION VIA FACSIMILE", included, but was not limited to, the following: "PURPOSE: Establish guidelines and direction to notify physicians by fax transmission. POLICY: The physician will be notified of certain condition changes as specified in this policy. Certain medical conditions may require immediate attention by phoning the physician or on-call physician.... ...2. Faxing messages to the physician will only occur if the condition does not require immediate attention....		specific corrective actions are prepared and/or executed in compliance with state and federal laws. **Please accept this plan of correction as our credible allegation of compliance with all regulatory requirements.** This facility informs the resident's physician of significant changes in resident condition. Corrective action for residents cited as affected Resident #70 Physician was notified and resident was sent to the Emergency Room for evaluation on 4-3-11 at 9:30 p.m. Identification of other residents at risk; All residents have the potential to be affected. Resident records were reviewed to assure physician notification regarding the development of fever or change in sputum color. Licensed nursing staff will use of Condition Change form for documentation of residents who have developed a fever and/or a change in sputum color in order to ensure timeliness of physician notification and interventions are in place for change in condition. (attachment A) All nursing staff will use form (attachment A) as an in-house tool for charting in nurses notes for all residents who have developed a fever and/or a change in sputum color in order to ensure timeliness of physician notification and interventions are in place for all change in conditions.Measures to ensure this deficient practice does not recur; Nursing staff will be	

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	...3. Conditions that require immediate attention will not be faxed. These would include, but are not limited to: chest pain, deformities with obvious fracture, falls resulting in pain, swelling or bruising, confusion of sudden onset and head injuries. The nurse will notify the physician immediately and document accordingly...." 3.) Review of a current undated facility policy, provided by the RN Consultant on 4/6/11 at 11:00 a.m., titled "PHYSICIAN NOTIFICATION PARAMETERS DEFINITIONS", included, but was not limited to, the following: "1. IMMEDIATE NOTIFICATION: A physician should be informed at the time the event occurs directly or via an		re-inserviced as of April 22, 2011 to 1.) Change in Condition Monitoring log, 2.) Physician Notification Parameters and policy 3.) Process for physician notification including physician notification via facsimile and the process for situations requiring immediately informing a resident' s physician of a significant change in a resident condition. 4.) Documentation of change of condition and physician notification utilizing the Change in Condition Monitoring flow sheet and documentation of condition change on the 24 hour nursing report. (Attachment C) Nursing staff will use the condition change form, for documenting assessment of vital signs and physician notification for residents who have developed a fever and/or a change in sputum color, to ensure communication of physician notification and intervention for fever or change in sputum color. (attachment A) The DON or designee will review the 24 hour daily report and review the change in condition monitoring log and nurses notes of residents noted to have experienced a change in condition, and assure appropriate physician notification of significant condition change. Monitoring of corrective action: The Director of Nursing or her designee will, each day, review the daily 24 hour report for resident change in condition and the change in	

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	electronic or telephone call system.... ...Condition... ...Immediate... ...Vital signs... ...Oral temp: > 101 degrees Rectal Temp: > 102 degrees..." 3.1-5(a)(2) 3.1-5(a)(3)		condition monitoring form with the resident's medical chart to ensure nursing staff are appropriately notifying the resident's physician regarding a fever or change in sputum color. The Director of Nursing will monitor to assure appropriate physician notification through review of 24 hour report and new physician orders during the morning Interdisciplinary (IDT) meeting. This audit will occur 5x weekly for 30days, 3x weekly for 30 days 1x weekly for 90days in total. Findings will be reported to the QA&A team on a weekly basis to ensure timeliness of notification of a physician if a resident has developed a fever and/or a change in sputum color. These monitors will become part of Randolph Nursing Home's Quality Assurance program to assure all patients with a change in condition are reported and conveyed to the physician timely. This review will continue on as part of Randolph Nursing Homes Quality Assurance Program.	
F0206	A nursing facility must establish and follow a written policy under which a resident whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if the resident requires the services provided by the facility; and is eligible for Medicaid nursing facility services.			
SS=D	Based on record review and interview the facility failed to allow 2 of 4 residents in a	F0206	F206 Preparation and/or execution of this plan of correction in general, or this	04/22/2011

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	sample of 16 return to the facility after a stay in an acute care facility. [Resident #'s C and D] Findings include: 1. Resident #D's clinical record was reviewed on 4/4/11 at 2:50 p.m. The resident's diagnoses included, but were not limited to, Psychosis; mood disorder; vascular dementia; deaf and mute. The resident had a 3/2/11, telephone physician's order for Resident #D to be sent out to the emergency room for possible psychiatric placement. Review of the 3/2/11, 7:45 a.m., Nurse's Note indicated the resident forcefully backhanded a nurse on the face when the nurse indicated to the resident he needed to adjust his clothing. Review of a 3/3/11, Social Services Progress Note indicated the Social Service Designee was notified on 3/3/11 of the resident's behavior on 3/2/11. The note indicated the resident was admitted to the psychiatric unit. During an interview with the Discharge Planner at an in-patient Geri-Psch Unit on 4/6/11 at 8:00 a.m., she indicated she had updated the facility of Resident D's		corrective action in particular, does not constitute an admission or agreement by Randolph Nursing Home of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. **Please accept this plan of correction as our credible allegation of compliance with all regulatory requirements.** Residents are readmitted to this facility following hospitalization or therapeutic leave in accordance with state and federal guidelines for readmission. Corrective action for affected residents Resident #C and Resident #D are residing in a Long Term Care Facility, Parkview in Muncie Indiana. Nursing staff and Administrative personnel will be re-inserviced as of April 22, 2011 to Federal Tag F206 and the state bed hold policy including readmission, of Medicaid-eligible residents, who are on therapeutic leave or hospitalized, to the first available bed. see (Attachment C) Identification of other residents at risk; All discharged residents are at risk. Audit of discharged residents was completed April 22, 2011 ensuring placement for each resident was found and appropriate discharge information communicated to the Responsible party. see (Attachment I) Nursing staff and	

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	progress during his stay on the unit. She indicated she notified the facility the resident was stable and could return to the facility. She indicated the facility refused to readmit the resident and did not assist in finding a new placement for the resident. During an interview with the Administrator and Social Service Designee on 4/5/11 at 3:50 p.m., they indicated they did not readmit the resident to the facility due to not being able to meet the resident's needs. They indicated the resident had been out to a psychiatric unit in February, 2011 and readmitted after that stay. They indicated the resident would become aggressive without provocation. The Social Service Designee indicated the resident was not meeting his Care Plan Goal of "I will not hit other people, if I become angry I will remove myself from the situation that is upsetting me." 2. Resident #C's clinical record was reviewed on 4/4/11 at 12:50 p.m. The resident's diagnoses included, but were not limited to, dementia with behavioral disturbances, personality disorders, and mood disorder. The resident had a 2/16/11, Physician's order for the resident to be transferred to		Administrative personnel will be re-inserviced April 22, 2011 to Federal Tag F206 and the State's Bed-hold policy which includes readmission, of Medicaid-eligible residents on therapeutic leave or hospitalized, to the first available bed. (Attachment C) Measures to ensure this deficient practice does not recur; Nursing staff and Administrative personnel will be re-inserviced April 22, 2011 to Federal Tag F206 and the State and facility Bed Hold Policy, including all Medicaid-eligible residents who are on therapeutic leave or hospitalized be readmitted to the first available semi private bed. (Attachment C) Monitoring of corrective action; The Social Service Director or designee will monitor resident discharges to ensure appropriate placement of discharged resident and appropriate discharge or readmission information communicated to the Responsible party utilizing a QA&A tool. (Attachment I). This Discharge QA&A audit will be completed on every discharged resident with any concerns reported immediately to the facility administrator. Results of QA&A discharge placement and resident/ responsible party notification monitor will be reported to the QA&A team weekly, and will become part of Randolph Nursing Homes Quality Assurance Program.	

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	the emergency room for a psychiatric evaluation and treatment. Review of a 2/16/11, Social Service Progress note indicated the resident was transferred to an in-patient psychiatric unit due to an increase in unwarranted accusations against staff members. During an interview with the Discharge Planner at an in-patient Geri-Psych Unit on 4/6/11 at 8:00 a.m., she indicated she had updated the facility of Resident C's progress during her stay on the unit. She indicated she notified the facility the resident was stable and could return to the facility. She indicated the facility refused to readmit the resident and did not assist in finding a new placement for the resident. During an interview with the Administrator and Social Service Designee on 4/5/11 at 3:50 p.m., they indicated they did not readmit the resident to the facility due to not being able to meet the resident's needs. They indicated the resident had been out to a psychiatric unit in December, 2010 and readmitted after that stay. They indicated the resident had increased behaviors of threatening the staff and making false accusations against the staff.			

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	This Federal tag relates to complaint #IN00087993. 3.1-12(a)(27)(A) 3.1-12(a)(27)(B)			
F0223	The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.			
SS=G	Based on record review and interview the facility failed to develop and implement a facility policy related to hiring employees with a felony conviction within the last 5 years for 1 of 5 employee files reviewed. (Employee CNA #1), and failed to ensure incidents of resident verbal abuse were reported to the Administrator, failed to ensure incidents of verbal abuse were investigated, failed to report incidents of verbal abuse to the appropriate state authority, failed to ensure interventions were implemented to prevent further incidents of verbal abuse for 2 of 2 residents reviewed who resided on the secured dementia unit who were subjected to verbal abuse (Resident #'S 39, 45,) , and failed to protect 1 of 1 resident from physical abuse (resident #29) which were committed by 1 of 1 resident reviewed	F0223	F223 Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by Randolph Nursing Home of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. **Please accept this plan of correction as our credible allegation of compliance with all regulatory requirements.** This facility has policy and procedures in place to promote the resident right to be free from abuse.Corrective action for affected residents Employee #1 was terminated. see (Attachment K) Residents #39 & #45 were	04/22/2011

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	for verbal and physical abuse in a sample of 16. (Resident #E) Findings include: 1.) Review of the current undated facility policy, titled "Incidents of Alleged Abuse" , provided by the administrator on 4/4/11 at 9:15 a.m., indicated the following, " Purpose: To ensure that each resident is free of physical, mental, verbal and sexual abuse, corporal punishment, mental and physical neglect, and involuntary seclusion. Residents must not be subjected to abuse by anyone including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends or other individuals. Policy: Residents residing in this facility will be treated with dignity and respect in accordance with their individual needs. They will not be subjected to physical, mental, verbal and sexual abuse, corporal punishment, mental and physical neglect, and involuntary seclusion.		interviewed for psychosocial outcomes of potential verbal abuse with no negative outcome noted by either resident. Residents #39 & #45 physicians and families were notified of the verbal abuse, a report was sent to Indiana State Department of Health. Resident #E is on One-to-One supervision until further notice. April 20, 2011 Social Service Director was re-educated to policy and procedure of Behavior Mgt, including identifying a resident's problem behavior including but not limited to Physical and/or verbal aggressive. Identify precipitants to behavior including people involved, environment, verbal and non-verbal Behavior, using a log to track behaviors and precipitating factors, education staff in manner of approaching resident and documentation of these findings on the Care Plan. (Attachment C) April 22, 2011, nursing staff and managers were reeducated to abuse recognition, intervention, and reporting of resident abuse. Identification of other residents at risk; All employee files have been reviewed to ensure all employees have not been convicted of a felony conviction within the last 5years. (Attachment L) Resident #E's chart was reviewed for indication of potential occurrence of verbal and/or physical abuse. Resident and staff interviews were completed April 22, 2011	

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	"Abuse" is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish, or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain or mental anguish. Physical Abuse: Includes, but is not limited to, hitting, slapping, punching, kicking, etc. It also includes controlling behavior through corporal punishment. Verbal Abuse: Refers to any use of oral, written, or gestured language that includes disparaging and derogatory terms to residents or their families, or within hearing distance, to describe residents regardless of their age, ability to comprehend or disability. Examples of verbal abuse include, but are not limited to, threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again....		with no finding indicating occurrence of abuse. All staff have been re-inserviced regarding recognition, intervention and reporting incidents of alleged abuse. (Attachment C)Measures to ensure this deficient practice does not recur; All employee files have been reviewed to ensure all employees that have been hired have not been convicted of a felony conviction within the last 5years. (Attachment L). Bookkeeper or designee will monitor criminal background check of all applicants prior to employment utilizing the Employee Pre-Employee Screening Policy. Findings will be reported to facility administrator who will confirm persons with a criminal conviction in the past 5 years are not hired. All staff have been re-inserviced regarding recognition, intervention and reporting incidents of alleged abuse. (Attachment C)Social Service Director was re-educated April 20, 2011 to policy and procedure of Behavior Management, (Attachment C); including identifying a resident's problem behavior including but not limited to physical and/or verbal aggressive behaviors. Identifying precipitants to behavior, using a log to track behaviors and precipitating factors, education of staff in manner of approaching resident and updating the	

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	Mental Abuse: Includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation. The procedures for reporting and documenting mental abuse are the same as reporting physical abuse.... Procedure: Should any type of abuse or alleged abuse occur, the following procedure is to be followed: 1. Any staff member witnessing an incident of physical, verbal, mental or sexual abuse, must intervene on behalf of resident. 2. After the resident's immediate safety is ensured, the staff member must then report the incident to the staff member in charge of the facility at the time of the incident. (If administrator is not in the building at the time of the incident, he/she will be notified immediately by the person in charge.)... 3. A thorough investigation is intimated of the allegations to gather pertinent information and verify the occurrence.		resident's Care Plan.Resident charts will be reviewed, by April 22, 2011, to ensure awareness and appropriate action for behaviors of Physical and/or verbally aggressive or socially inappropriate or disruptive behaviors. (attachment I) April 22, 2011, Nursing staff and managers were reeducated to abuse recognition, intervention, and reporting of resident abuse.Monitoring of corrective action; On April 6, 2011 Resident #E was placed on one-to-one monitoring until further notice Social Service Director will track behaviors and precipitating factors, review with the IDT to develop care plan and educate staff to preventative interventions. All Charts will be reviewed, by April 22, 2011, to ensure awareness and appropriate action for behaviors of Physical and/or verbally aggressive or socially inappropriate or disruptive behaviors. (attachment I) The Social Service Director or her designee will monitor to assure use form (Attachment I) 5x weekly for 30days, 3 times weekly for 30 days, 1x weekly for 90 days in total. Findings will be reported to the QA&A team for review weekly.The Bookkeeper or designee will monitor all applicants for felony conviction status prior to employment and report findings of felony conviction to administrator (Attachment L). Facility	

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	4. There must be appropriate steps taken to prevent further (potential) abuse while the investigation is in progress..." 2) .The clinical record for resident #E was reviewed on 4/3/11 at 4:30 p.m. Resident #E's current diagnoses included, but were not limited to, Huntington's disease, mood disorder and dementia with agitation. Resident #E had a current healthcare plan, which originated 4/26/10, and was updated 1/12/11, which indicated the resident had a problem listed as, resident has a history of becoming abusive to others. Interventions for this problem included, document all behaviors, interventions used and the residents response to interventions used. Nursing note entries from Resident #E's clinical record indicated the following, 10/29/10 at 5:00 p.m., "resident has been verbally [sic] to other residents at table for meals. When tried to redirect resident resident became very hateful cursing at staff. Refused to leave dining room when finished instead continued to talk bad to tablemate. Social service made aware."		administrator will assure persons with a felony conviction are reviewed are hired or decline employment per Pre-Employment Screening Policy. Employees with a felony conviction within the past five years are ineligible for hire. Findings will be reported to the QA&A team at least quarterly. This process will become part of Randolph Nursing Homes Quality Assurance Program.	

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10/30/10 at 3:00 p.m., " Resident has been verbally taunting other residents at DR [dining room] table, saying "you're so ugly, I'd just shoot you", attempted to redirect resident. continues [with] behaviors."

10/31/10, at 3:00 p.m. "Continues [with] behaviors when @ [at] table in DR . called other resident gay, ugly and worthless, other resident did not respond back, attempted to redirect resident [without] success."

11/1/10 at 10:00 a.m., ..."very rude to other res [resident] during bkfst [breakfast], unable to redirect, refused to leave DR, calling other res "homo [homosexual], states res needs shot in head, "ugly"."

11/6/10 at 2:00 p.m., " Resident conts [continues] [with] behaviors during meals - calls tablemate ugly and states "they are going to shoot you" called him a macho man, other resident did not respond to comments."

11/7/10 at 6 p.m., "Res has had cont [continued] behaviors at meal [times] called other res ugly - states he needs a gun to shoot other res - also tries to provoke other res to throw spill proof cup

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	at said res, other res has not been initiating confrontation, unable to redirect." 11/8/10 at 1:00 p.m., ..."cont to be rude to other residents calling them "homos" stating they are ugly and need to be shot, resident undirectable, explained to res that behavior is unacceptable and he needs to leave the dining room, res refuses to leave or quit making comments..." 11/9/10 (no time) "cont [continues] [with] comments to other resident [Resident#39], undirectable." 11/10/10 at 10:00 a.m., "resident very verbally rude to [Resident #39] calling him a "homo" and saying res needs "shot in the head because he is so ugly" upon staff redirection res does not stop, just continues louder. Happens in dining room during meal time, removed [Resident #39] and bad mouthing continues." 11/11/10 at 10:00 a.m.. " Res conts to make rude comments to [Resident #39], calls him "homo", "ugly" tells him he's not getting nothing..." 11/12/10 at 8:00 a.m." Resident conts to sit in dining room and make rude remarks to [Resident #39] calling res a "homo"			

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	and saying res is so ugly he needs to be shot unable to remove, redirect from dining room. Explained several x's [times] that behavior is unacceptable...." 11/13/10 at 3:00 p.m. "conts @ meals to make rude comments to resident [Resident#39]..." 11/17/10 at 9:00 a.m. resident continues to be disrespectful at mealtime to res [Resident #39] stating "you are an ugly homo, I should blow your head off" when trying to redirect res to stop being rude and disruptive res states "I know my rights" unable to redirect or get to remove self from table...' 11/25/10 at 9:30 a.m., "Resident very hateful [with] res [Resident #45]" in dining room this a.m. for breakfast yelling at res [Resident #45] to "sit down stupid if you were a human being you could comprehend..." 11/30/10 8:00 a.m. "Resident conts to be verbally hateful [with] other residents during breakfast, calling them "ugly" ..." 12/3/10 at 1:00 p.m. "Resident continues to be verbally rude to other residents when try to redirect res gets louder and more verbal, call other residents "homo, ugly and ignorant, says they need to be			

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	shot in the head ..." 12/6/10 (no time) "conts [with] verbal abuse towards other res, redirection unsuccessful..." 12/8/10 (no time) "conts [with] behaviors and rudeness towards other res calling res "homo" "ugly" states needs to be shot", flips said res off [with] middle finger, redirection unsuccessful..." 12/11/10 at 2:00 p.m. "continues to make rude gestures and yell to another resident at meal time..." 12/21/10 at 6:00 p.m., "during shift report CNA summoned writer to DR tablemate [Resident #29] was holding cheek stated that [Resident #E] had smacked her on the cheek, writer and on coming nurse tried to remove [Resident #E] from the table when res stood up and was cursing and yelling stating "I'm not going anywhere, I have my rights, res then hit other nurse and pushed writer, upon redirection offering to take res tray to room so he could finish and there res punched writer, finally removed			

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	from DR and taken to room." The clinical record indicated the Administrator and the resident's physician was called. The resident was placed on 15 minute checks to monitor behavior. The resident was transferred to an inpatient psychiatric unit at 8:30 p.m. on 12/21/10. The resident returned to the facility on 12/28/10. .3) During an interview with the Administrator on 4/3/11 at 6:45 p.m. .additional information was requested related to the reporting to the state agency of the incidents of verbal abuse noted above by Resident #E. The Administrator was asked to provide documentation of any interventions the facility implemented following the verbal abuse incidents that were taken to prevent further incidents from reoccurring. The Administrator was asked for any investigations that were completed following the incidents of verbal abuse documented in Resident #E's clinical record. During an interview with the Administrator on 4/4/11 at 5:30 p.m. she indicated the facility had no information to provide related to the verbal abuse incidents committed by Resident #E noted on the dates and times above. The Administrator indicated the nurses who documented the verbal abuse incidents in the clinical record failed to report the incidents to anyone. She further indicated she was not aware of any of the verbal abuse incidents with Resident #E. She indicated the facility had not investigated any of the verbal			

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	abuse incidents. The Administrator indicated she had not reported any of the verbal abuse incidents to the state agency. 3.1-27(a)(1)			
F0225	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification			

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	agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
SS=G	A. Based on record review and interview the facility failed to develop and implement a facility policy related to hiring employees with a felony conviction within the last 5 years for 1 of 5 employee files reviewed. (Employee CNA #1), and failed to ensure incidents of resident verbal abuse were reported to the Administrator, failed to ensure incidents of verbal abuse were investigated, failed to report incidents of verbal abuse to the appropriate state authority, failed to ensure interventions were implemented to prevent further incidents of verbal abuse for 2 of 2 residents reviewed who resided on the secured dementia unit who were subjected to verbal abuse (Resident #'S 39, 45,) , and failed to protect 1 of 1 resident from physical abuse (resident #29) which were committed by 1 of 1 resident reviewed for verbal and physical abuse in a sample of 16. (Resident #E) B. Based on record review and interview the facility failed to ensure an employee who was hired by the facility to provide direct care to residents had not been convicted of a felony within the last 5 years for 1 of 5 employee files reviewed. (Employee CNA #1) Findings include:	F0225	F 225 Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by Randolph Nursing Home of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. **Please accept this plan of correction as our credible allegation of compliance with all regulatory requirements.** This facility has policy and procedures in place to promote the resident right to be free from abuse and for pre-hire screening of applicants. Corrective action for affected residents Employee C.N.A #1 has been terminated. (Attachment K) Residents #39 & #45 were interviewed and their records reviewed for psychosocial outcomes of verbal abuse (without findings), Residents #39 & #45 physicians and families were notified of the verbal abuse, a report was sent to Indiana State Department of Health.Resident #E was placed on One-to-One supervision until further notice. All staff have been re-inserviced regarding recognition, intervention and reporting incidents of alleged	04/22/2011

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	A1.) Review of the current undated facility policy, titled "Incidents of Alleged Abuse" , provided by the administrator on 4/4/11 at 9:15 a.m., indicated the following, " Purpose: To ensure that each resident is free of physical, mental, verbal and sexual abuse, corporal punishment, mental and physical neglect, and involuntary seclusion. Residents must not be subjected to abuse by anyone including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends or other individuals. Policy: Residents residing in this facility will be treated with dignity and respect in accordance with their individual needs. They will not be subjected to physical, mental, verbal and sexual abuse, corporal punishment, mental and physical neglect, and involuntary seclusion. "Abuse" is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish, or		abuse. (Attachment C)Social Service Director was re-educated April 20, 2011 to policy and procedure of Behavior Mgt, see (Attachment C) including identifying a resident's problem behavior including but not limited to Physical and/or verbal aggressive. Identify precipitants to behavior including people involved, environment, verbal and non-verbal behavior and using a log to track behaviors, precipitating factors, education of staff regarding interventions and manner of approaching resident, and documentation of these findings on the Care Plan. Identification of other residents at risk; All employee files have been reviewed to ensure all employees that have been hired have not been convicted of a felony conviction within the last 5years. see (Attachment L) All staff have been re-inserviced regarding recognition, intervention and reporting incidents of alleged abuse. (Attachment C)Social Service Director was re-educated to the Policies and Procedure's of Behavior Mgt, see (Attachment C) including identifying a resident's problem behavior including but not limited to Physical and/or verbal aggression. Identify precipitants to behavior including People involved, Environment, Verbal and Non-Verbal Behavior and using a Log to track behaviors and precipitating	

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	deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain or mental anguish. Physical Abuse: Includes, but is not limited to, hitting, slapping, punching, kicking, etc. It also includes controlling behavior through corporal punishment. Verbal Abuse: Refers to any use of oral, written, or gestured language that includes disparaging and derogatory terms to residents or their families, or within hearing distance, to describe residents regardless of their age, ability to comprehend or disability. Examples of verbal abuse include, but are not limited to, threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again.... Mental Abuse: Includes, but is not limited to, humiliation, harassment, threats of		factors, and educate staff in manner's of approaching residents and appropriate documentation on the resident's Care Plan.Resident #E's chart was fully reviewed to ensure no more verbal and/or physical abuse had occurred.Measures to ensure this deficient practice does not recur; Employee files have been reviewed to ensure all employees that have been hired have not been convicted of a felony conviction within the last 5years. (Attachment L) April 22, 2011 All staff have been re-inserviced regarding recognition, intervention and reporting incidents of alleged abuse. (Attachment C)Social Service Director was re-educated to the Policies and Procedure's of Behavior Mgt, see (Attachment C) including identifying a resident's problem behavior including but not limited to Physical and/or verbal aggression. Identify precipitants to behavior including People involved, Environment, Verbal and Non-Verbal Behavior and using a Log to track behaviors and precipitating factors, and educate staff in manner's of approaching residents and appropriate documentation on the resident's Care Plan.April 6, 2011 Resident #E was placed on one-to-one monitoring until further notice.Resident #E's chart was fully reviewed to ensure no more verbal and/or physical abuse had	

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	punishment or deprivation. The procedures for reporting and documenting mental abuse are the same as reporting physical abuse.... Procedure: Should any type of abuse or alleged abuse occur, the following procedure is to be followed: 1. Any staff member witnessing an incident of physical, verbal, mental or sexual abuse, must intervene on behalf of resident. 2. After the resident's immediate safety is ensured, the staff member must then report the incident to the staff member in charge of the facility at the time of the incident. (If administrator is not in the building at the time of the incident, he/she will be notified immediately by the person in charge.)... 3. A thorough investigation is intimated of the allegations to gather pertinent information and verify the occurrence. 4. There must be appropriate steps taken to prevent further (potential) abuse while the investigation is in progress..."		occurred. All Charts were reviewed to ensure behaviors of physical and/or verbally aggression or socially inappropriate or disruptive behaviors have been appropriately addressed. (attachment I) Monitoring of corrective action; All employee files have been reviewed to ensure all employees that have been hired have not been convicted of a felony conviction within the last 5years. see (Attachment L). Facility administrator will assure persons with a felony conviction are reviewed and decline employment per Pre-Employment Screening Policy. The Bookkeeper or her designee will use form (Attachment L) for all new hires, 5x weekly for 30 days, 3x weekly for 30 days, 1x weekly for 90 days in total. Findings will be reported to the QA&A team on a weekly basis. Social Service Director was re-educated to Policies and Procedure's of Behavior Mgt, including identifying a resident's problem behavior including but not limited to Physical and/or verbal aggression. Identify precipitants to behavior including People involved, Environment, Verbal and Non-Verbal Behavior and using a Log to track behaviors and precipitating factors, and educate staff in manners of approaching residents. Lastly, document these findings on the	

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	A2) .The clinical record for resident #E was reviewed on 4/3/11 at 4:30 p.m. Resident #E's current diagnoses included, but were not limited to, Huntington's disease, mood disorder and dementia with agitation. Resident #E had a current healthcare plan, which originated 4/26/10, and was updated 1/12/11, which indicated the resident had a problem listed as, resident has a history of becoming abusive to others. Interventions for this problem included, document all behaviors, interventions used and the residents response to interventions used. Nursing note entries from Resident #E's clinical record indicated the following, 10/29/10 at 5:00 p.m., "resident has been verbally [sic] to other residents at table for meals. When tried to redirect resident resident became very hateful cursing at staff. Refused to leave dining room when finished instead continued to talk bad to tablemate. Social service made aware." 10/30/10 at 3:00 p.m., " Resident has been verbally taunting other residents at DR [dining room] table, saying "you're so ugly, I'd just shoot you", attempted to		Plan of Care. (Attachment C) All Charts have been reviewed to ensure behaviors of physical and/or verbally aggressive or socially inappropriate or disruptive behaviors are recognized and responded to appropriately. (Attachment I). Social Service Director reported findings of this audit to the Administrator and QA/A committee. The Social Service Director or her designee will use form (Attachment I) for monitoring 5x weekly for 30 days, 3x weekly for 30 days, 1x weekly for 90 days in total. Findings will be reported to the Administrator as well as to the QA&A committee weekly.Facility administrator will assure persons with a felony conviction are reviewed and decline employment per Pre-Employment Screening Policy. Employees with a felony conviction within the past five years are ineligible for hire. Findings will be reported to the QA&A team at least quarterly, and will become part of Randolph Nursing Homes Quality Assurance Program.	

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	redirect resident. continues [with] behaviors." 10/31/10, at 3:00 p.m. "Continues [with] behaviors when @ [at] table in DR . called other resident gay, ugly and worthless, other resident did not respond back, attempted to redirect resident [without] success." 11/1/10 at 10:00 a.m., ..."very rude to other res [resident] during bkfst [breakfast], unable to redirect, refused to leave DR, calling other res "homo [homosexual], states res needs shot in head, "ugly"." 11/6/10 at 2:00 p.m., " Resident conts [continues] [with] behaviors during meals - calls tablemate ugly and states "they are going to shoot you" called him a macho man, other resident did not respond to comments." 11/7/10 at 6 p.m., "Res has had cont [continued] behaviors at meal [times] called other res ugly - states he needs a gun to shoot other res - also tries to provoke other res to throw spill proof cup at said res, other res has not been initiating confrontation, unable to redirect." 11/8/10 at 1:00 p.m., ..."cont to be rude to			

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	other residents calling them "homos" stating they are ugly and need to be shot, resident undirectable, explained to res that behavior is unacceptable and he needs to leave the dining room, res refuses to leave or quit making comments..." 11/9/10 (no time) "cont [continues] [with] comments to other resident [Resident#39], undirectable." 11/10/10 at 10:00 a.m., "resident very verbally rude to [Resident #39] calling him a "homo" and saying res needs "shot in the head because he is so ugly" upon staff redirection res does not stop, just continues louder. Happens in dining room during meal time, removed [Resident #39] and bad mouthing continues." 11/11/10 at 10:00 a.m.. " Res conts to make rude comments to [Resident #39], calls him "homo", "ugly" tells him he's not getting nothing..." 11/12/10 at 8:00 a.m." Resident conts to sit in dining room and make rude remarks to [Resident #39] calling res a "homo" and saying res is so ugly he needs to be shot unable to remove, redirect from dining room. Explained several x's [times] that behavior is unacceptable...."			

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	11/13/10 at 3:00 p.m. "conts @ meals to make rude comments to resident [Resident#39]..." 11/17/10 at 9:00 a.m. resident continues to be disrespectful at mealtime to res [Resident #39] stating "you are an ugly homo, I should blow your head off" when trying to redirect res to stop being rude and disruptive res states "I know my rights" unable to redirect or get to remove self from table...' 11/25/10 at 9:30 a.m., "Resident very hateful [with] res [Resident #45]" in dining room this a.m. for breakfast yelling at res [Resident #45] to "sit down stupid if you were a human being you could comprehend..." 11/30/10 8:00 a.m. "Resident conts to be verbally hateful [with] other residents during breakfast, calling them "ugly" ..." 12/3/10 at 1:00 p.m. "Resident continues to be verbally rude to other residents when try to redirect res gets louder and more verbal, call other residents "homo, ugly and ignorant, says they need to be shot in the head ..." 12/6/10 (no time) "conts [with] verbal abuse towards other res, redirection unsuccessful..."			

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12/8/10 (no time) "conts [with] behaviors and rudeness towards other res calling res "homo" "ugly" states needs to be shot", flips said res off [with] middle finger, redirection unsuccessful..."

12/11/10 at 2:00 p.m. "continues to make rude gestures and yell to another resident at meal time..."

12/21/10 at 6:00 p.m., "during shift report CNA summoned writer to DR tablemate [Resident #29] was holding cheek stated that [Resident #E] had smacked her on the cheek, writer and on coming nurse tried to remove [Resident #E] from the table when res stood up and was cursing and yelling stating "I'm not going anywhere, I have my rights, res then hit other nurse and pushed writer, upon redirection offering to take res tray to room so he could finish and there res punched writer, finally removed from DR and taken to room." The clinical record indicated the Administrator and the resident's physician was called. The resident

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was placed on 15 minute checks to monitor behavior. The resident was transferred to an inpatient psychiatric unit at 8:30 p.m. on 12/21/10. The resident returned to the facility on 12/28/10.

A.3) During an interview with the Administrator on 4/3/11 at 6:45 p.m. .additional information was requested related to the reporting to the state agency of the incidents of verbal abuse noted above by Resident #E. The Administrator was asked to provide documentation of any interventions the facility implemented following the verbal abuse incidents that were taken to prevent further incidents from reoccurring. The Administrator was asked for any investigations that were completed following the incidents of verbal abuse documented in Resident #E's clinical record.

During an interview with the Administrator on 4/4/11 at 5:30 p.m. she indicated the facility had no information to provide related to the verbal abuse incidents committed by Resident #E noted on the dates and times above. The Administrator indicated the nurses who documented the verbal abuse incidents in the clinical record failed to report the incidents to anyone. She further indicated she was not aware of any of the verbal abuse incidents with Resident #E. She indicated the facility had not investigated any of the verbal abuse incidents. The Administrator indicated she had not reported any of the verbal abuse incidents to the state agency.

B1.) Review of the current undated facility policy, titled "Criminal Background Checks", provided by

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	the Administrator on 4/5/11 at 1:30 p.m., indicated the following, " Indiana: Complete the "Request for Limited Criminal History Information"... within three (3) business days from date a person is employed as a nurse aide or other licensed employee for a copy of the person's state nurse aide registry report from the department and a criminal history from the Indiana Central Repository for criminal history information..." B2.) Review of the employee files on 4/5/11 at 3:45 p.m. indicated Employee CNA #1 was hired by the facility on 1/13/11. The "Indiana State Police Limited Criminal History" report for Employee CNA #1, dated 1/24/11 indicated the following, "Arrest 1 01/13/2009 Arrest Detail: Agency: [Name of County Sheriff Department] Original Charge: Fraud Original Charge: Theft Class / Level : D Felony Original Charge: Forgery Prosecutor / Court Detail: Cause Number: [Number Listed] Filed Charge: Theft Class / Level : D Felony Amended Charge: Theft Class / Level D Felony Disposition: Guilty Sentence: 18 M [months]			

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	Probation: 18M..." During an interview with the Administrator on 4/5/11 at 4:15 p.m. she indicated the facility had no policy related to employee hiring eligibility based on results of the employee's "Limited Criminal History" information. She further indicated she was unaware Employee CNA #1 had been convicted of a felony theft charge. 3.1-27(a)(1)			
F0226 SS=G	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview the facility failed to follow the facility abuse policy related to incidents of verbal abuse for 2 of 2 residents reviewed who resided on the secured dementia unit who were subjected to verbal abuse (Resident #'S 39, 45) which were committed by 1 of 1 resident reviewed for verbal abuse in a sample of 16. (Resident #E)and failed to protect 1 of 1 resident from physical abuse (resident #29) which were committed by 1 of 1 resident reviewed for verbal and physical abuse in a sample of 16. (Resident #E) and the facility failed to develop and implement a facility policy related to	F0226	F 226 Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by Randolph Nursing Home of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. **Please accept this plan of correction as our credible allegation of compliance with all regulatory requirements.** This s facility has policies prohibiting resident abuse including screening of applicants	04/22/2011

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	hiring employees with a felony conviction with in the last 5 years for 1 of 5 employee files reviewed. (Employee CNA #1) Findings include: 1.) Review of the current undated facility policy, titled "Incidents of Alleged Abuse" , provided by the administrator on 4/4/11 at 9:15 a.m., indicated the following, " Purpose: To ensure that each resident is free of physical, mental, verbal and sexual abuse, corporal punishment, mental and physical neglect, and involuntary seclusion. Residents must not be subjected to abuse by anyone including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends or other individuals. Policy: Residents residing in this facility will be treated with dignity and respect in accordance with their individual needs. They will not be subjected to physical, mental, verbal and sexual abuse, corporal punishment, mental and physical neglect,		through assuring appropriate government regulated licensing, reference checks and criminal background check. Corrective action for affected residents Employee C.N.A #1 has been terminated. (Attachment K) Residents #39 & #45 were interviewed and their records reviewed for psychosocial outcomes of verbal abuse (without findings), Residents #39 & #45 physicians and families were notified of the verbal abuse, a report was sent to Indiana State Department of Health. Resident #E was placed on One-to-One supervision until further notice. All staff have been re-inserviced by regarding recognition, intervention and reporting incidents of alleged abuse. (Attachment C)Social Service Director was re-educated April 20, 2011 to policy and procedure of Behavior Mgt, see (Attachment C) including identifying a resident's problem behavior including but not limited to Physical and/or verbal aggressive. Identify precipitants to behavior including People involved, Environment, Verbal and Non-Verbal Behavior and using a log to track behaviors and precipitating factors, and educate staff in manner of approaching resident. Document these findings on the Care Plan. Identification of other residents at risk; All employee files have been reviewed to	

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	and involuntary seclusion. "Abuse" is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish, or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain or mental anguish. Physical Abuse: Includes, but is not limited to, hitting, slapping, punching, kicking, etc. It also includes controlling behavior through corporal punishment. Verbal Abuse: Refers to any use of oral, written, or gestured language that includes disparaging and derogatory terms to residents or their families, or within hearing distance, to describe residents regardless of their age, ability to comprehend or disability. Examples of verbal abuse include, but are not limited to, threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never be able to		ensure all employees that have been hired have not been convicted of a felony conviction within the last 5years. see (Attachment L) All staff have been re-inserviced regarding Incidents of Alleged Abuse. see (Attachment C)Social Service Director was re-educated to the Policies and Procedure's of Behavior Mgt, see (Attachment C) including identifying a resident's problem behavior including but not limited to Physical and/or verbal aggression. Identify precipitants to behavior including People involved, Environment, Verbal and Non-Verbal Behavior and using a Log to track behaviors and precipitating factors, and educate staff in manner's of approaching residents and appropriate documentation on the resident's Care Plan.Resident #E's chart was fully reviewed by the facility administrator and Director of Operations April 5, 2011 for identification of occurrence of, or residents potentially affected by, verbal and/or physical abuse.Measures to ensure this deficient practice does not recur; Employee files have been reviewed to ensure all employees that have been hired have not been convicted of a felony conviction within the last 5years. (Attachment L) April 19, 2011 All staff have been re-inserviced regarding Incidents of Alleged Abuse. (Attachment C)Social	

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	see his/her family again.... Mental Abuse: Includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation. The procedures for reporting and documenting mental abuse are the same as reporting physical abuse.... Procedure: Should any type of abuse or alleged abuse occur, the following procedure is to be followed: 1. Any staff member witnessing an incident of physical, verbal, mental or sexual abuse, must intervene on behalf of resident. 2. After the resident's immediate safety is ensured, the staff member must then report the incident to the staff member in charge of the facility at the time of the incident. (If administrator is not in the building at the time of the incident, he/she will be notified immediately by the person in charge.)... 3. A thorough investigation is intimated of the allegations to gather pertinent information and verify the occurrence.		Service Director was re-educated to Policies and Procedure's of Behavior Mgt, see (Attachment C), including identifying a resident's problem behavior including but not limited to physical and/or verbal aggression. Identify precipitants to behavior including People involved, Environment, Verbal and Non-Verbal Behavior and using a Log to track behaviors and precipitating factors, and educate staff in manner of approaching residents. Lastly, document these findings on the Plan of Care.April 6, 2011 Resident #E was placed on one-to-one monitoring until further notice.Resident #E's chart was fully reviewed to ensure no more verbal and/or physical abuse had occurred. All Charts have been reviewed to ensure behaviors of physical and/or verbally aggressive or socially inappropriate or disruptive behaviors are recognized and responded to appropriately. (attachment I). Social Service Director reported findings of this audit to the Administrator and QA/A committee. Monitoring of corrective action; All employee files have been reviewed to ensure all employees that have been hired have not been convicted of a felony conviction within the last 5years. see (Attachment L) The Bookkeeper or her designee will use form (Attachment L) for all new hires,	

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	4. There must be appropriate steps taken to prevent further (potential) abuse while the investigation is in progress..." 2) .The clinical record for resident #E was reviewed on 4/3/11 at 4:30 p.m. Resident #E's current diagnoses included, but were not limited to, Huntington's disease, mood disorder and dementia with agitation. Nursing note entries from Resident #E's clinical record indicated the following, 10/29/10 at 5:00 p.m., "resident has been verbally [sic] to other residents at table for meals. When tried to redirect resident resident became very hateful cursing at staff. Refused to leave dining room when finished instead continued to talk bad to tablemate. Social service made aware." 10/30/10 at 3:00 p.m., " Resident has been verbally taunting other residents at DR [dining room] table, saying "you're so ugly, I'd just shoot you", attempted to redirect resident. continues [with] behaviors." 10/31/10, at 3:00 p.m. "Continues [with] behaviors when @ [at] table in DR .		5x weekly for 30 days, 3x weekly for 30 days, 1x weekly for 90 days in total. Findings will be reported to the QA&A team on a weekly basis. The Social Service Director or her designee will monitor resident behaviors (Attachment I) 5x weekly for 30 days, 3x weekly for 30 days, 1x weekly for 90 days in total. Findings will be reported to the Administrator as well as to the QA&A committee weekly.Facility administrator will assure persons with a felony conviction are reviewed are hired or decline employment per Pre-Employment Screening Policy. Employees with a felony conviction within the past five years are ineligible for hire. Findings will be reported to the QA&A team at least quarterly, and will become part of Randolph Nursing Homes Quality Assurance Program.	

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	called other resident gay, ugly and worthless, other resident did not respond back, attempted to redirect resident [without] success." 11/1/10 at 10:00 a.m., ..."very rude to other res [resident] during bkfst [breakfast], unable to redirect, refused to leave DR, calling other res "homo [homosexual], states res needs shot in head, "ugly"." 11/6/10 at 2:00 p.m., " Resident conts [continues] [with] behaviors during meals - calls tablemate ugly and states "they are going to shoot you" called him a macho man, other resident did not respond to comments." 11/7/10 at 6 p.m., "Res has had cont [continued] behaviors at meal [times] called other res ugly - states he needs a gun to shoot other res - also tries to provoke other res to throw spill proof cup at said res, other res has not been initiating confrontation, unable to redirect." 11/8/10 at 1:00 p.m., ..."cont to be rude to other residents calling them "homos" stating they are ugly and need to be shot, resident undirectable, explained to res that behavior is unacceptable and he needs to leave the dining room, res refuses to leave			

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or quit making comments..."

11/9/10 (no time) "cont [continues] [with] comments to other resident [Resident#39], undirectable."

11/10/10 at 10:00 a.m., "resident very verbally rude to [Resident #39] calling him a "homo" and saying res needs "shot in the head because he is so ugly" upon staff redirection res does not stop, just continues louder. Happens in dining room during meal time, removed [Resident #39] and bad mouthing continues."

11/11/10 at 10:00 a.m.. " Res conts to make rude comments to [Resident #39], calls him "homo", "ugly" tells him he's not getting nothing..."

11/12/10 at 8:00 a.m." Resident conts to sit in dining room and make rude remarks to [Resident #39] calling res a "homo" and saying res is so ugly he needs to be shot unable to remove, redirect from dining room. Explained several x's [times] that behavior is unacceptable...."

11/13/10 at 3:00 p.m. "conts @ meals to make rude comments to resident [Resident#39]..."

11/17/10 at 9:00 a.m. resident continues

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	to be disrespectful at mealtime to res [Resident #39] stating "you are an ugly homo, I should blow your head off" when trying to redirect res to stop being rude and disruptive res states "I know my rights" unable to redirect or get to remove self from table...' 11/25/10 at 9:30 a.m., "Resident very hateful [with] res [Resident #45]" in dining room this a.m. for breakfast yelling at res [Resident #45] to "sit down stupid if you were a human being you could comprehend..." 11/30/10 8:00 a.m. "Resident conts to be verbally hateful [with] other residents during breakfast, calling them "ugly" ..." 12/3/10 at 1:00 p.m. "Resident continues to be verbally rude to other residents when try to redirect res gets louder and more verbal, call other residents "homo, ugly and ignorant, says they need to be shot in the head ..." 12/6/10 (no time) "conts [with] verbal abuse towards other res, redirection unsuccessful..." 12/8/10 (no time) "conts [with] behaviors and rudeness towards other res calling res "homo" "ugly" states needs to be shot", flips said res off [with] middle finger,			

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	redirection unsuccessful..." 12/11/10 at 2:00 p.m. "continues to make rude gestures and yell to another resident at meal time..." 3.) During an interview with the Administrator on 4/3/11 at 6:45 p.m. .additional information was requested related to the reporting to the state agency of the incidents of verbal abuse noted above by Resident #E. The Administrator was asked to provide documentation of any interventions the facility implemented following the verbal abuse incidents that were taken to prevent further incidents from reoccurring. The Administrator was asked for any investigations that were completed following the incidents of verbal abuse documented in Resident #E's clinical record. During an interview with the Administrator on 4/4/11 at 5:30 p.m. she indicated the facility had no information to provide related to the verbal abuse incidents committed by Resident #E noted on the dates and times above. The Administrator indicated the facility did not follow their abuse policy. She indicated the nurses who documented the verbal abuse incidents in the clinical			

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	record failed to report the incidents to anyone. She further indicated she was not aware of any of the verbal abuse incidents with Resident #E. She indicated the facility had not investigated any of the verbal abuse incidents. The Administrator indicated she had not reported any of the verbal abuse incidents to the state agency. 4.) Review of the current undated facility policy, titled "Criminal Background Checks", provided by the Administrator on 4/5/11 at 1:30 p.m., indicated the following, " Indiana: Complete the "Request for Limited Criminal History Information"... within three (3) business days from date a person is employed as a nurse aide or other licensed employee for a copy of the person's state nurse aide registry report from the department and a criminal history from the Indiana Central Repository for criminal history information..." 5.) Review of the employee files on 4/5/11 at 3:45 p.m. indicated Employee CNA #1 was hired by the facility on 1/13/11. The "Indiana State Police Limited Criminal History" report for Employee			

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	CNA #1, dated 1/24/11 indicated the following, "Arrest 1 01/13/2009 Arrest Detail: Agency: [Name of County Sheriff Department] Original Charge: Fraud Original Charge: Theft Class / Level : D Felony Original Charge: Forgery Prosecutor / Court Detail: Cause Number: [Number Listed] Filed Charge: Theft Class / Level : D Felony Amended Charge: Theft Class / Level D Felony Disposition: Guilty Sentence: 18 M [months] Probation: 18M..." 6.) During an interview with the Administrator on 4/5/11 at 4:15 p.m. she indicated the facility had no policy related to employee hiring based on results of the employee's "Limited Criminal History" information. She further indicated she was unaware Employee CNA #1 had been convicted of			

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	a felony theft charge. 3.1-28(a)			
F0250	The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.			
SS=G	Based on record review and interview the facility failed to ensure Social Services reviewed and intervened following incidents of resident verbal abuse, failed to ensure incidents of verbal abuse were investigated, , failed to ensure interventions were implemented to prevent further incidents of verbal abuse for 2 of 2 residents reviewed who were subjected to verbal abuse (Resident #'S 39, 45,) , failed to protect 1 of 1 resident from physical abuse (resident #29) which were committed by 1 of 1 resident reviewed for verbal and physical abuse (Resident #E), and the facility failed to ensure the Social Services assisted residents with discharge planning for 2 of 3 residents reviewed who were discharged from the facility (Resident #'s C, D) in a sample of 16. Findings include: 1.) Review of the current undated facility policy, titled "Behavior Management	F0250	F 250 Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by Randolph Nursing Home of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. **Please accept this plan of correction as our credible allegation of compliance with all regulatory requirements.** This facility provides medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident.Corrective action for affected residents Previously discharged residents C and D are residing at Parkview of Muncie. Residents #39 and Resident #45 were interviewed and each was without recollection of the event. Both families and physicians were notified of the subjected verbal	04/22/2011

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	-General", provided by the Administrator on 4/5/11 at 1:30 p.m. indicated the following, "Policy: The Social Services Department will provide or make referrals to provide appropriate interventions and input to assist in establishing a plan of treatment for those residents as needing "Behavior Management." Procedure: The Social Services Department along with the multidisciplinary team will: 1. Identify a resident's problem behavior (i.e. behavior that may adversely affect the well being of the resident themselves, other residents, etc.) including, but not limited to: a. Physically and/or verbally aggressive (abusive)... f. Socially inappropriate or disruptive behavior 2. Identify precipitants to behavior, including, but not limited to: a. People involved b. Environment		abuse.On April 6, 2011 Resident #E was placed on one-to-one monitoring until further notice The Social Service Director was re-educated to Job Description including responsibility for planning, developing, organizing, implementing, evaluating and directing the Social Service programs. Assess each resident' s psychosocial needs and develop the plan of care. Assist with discharge planning, development and implementation of the discharge plan. Social Service Director was re-educated to policy and procedure of Behavior Mgt, including identifying a resident's problem behavior including but not limited to physical and/or verbal aggression. Identify precipitants to behavior including people involved, environment, verbal and non-verbal behavior and using a log to track behaviors and precipitating factors, and educate staff in manner of approaching resident. As well as, documentation updating the resident's Care Plan. (Attachment C)Identification of other residents at risk; Audit of discharged resident records was completed ensuring placement for the resident was found and appropriate communication to the responsible party. (Attachment I) Resident and staff interviews were completed to determine indication of other occurrences of potential verbal or physical	

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	c. Verbal and non-verbal behavior Use the "Behavior Monitoring Log" to track behaviors and precipitating factors and the "Evaluation for New Or Worsening Behavioral Symptoms" to thoroughly assess resident behaviors. 3. Describe the impact of resident behavior on: a. Resident exhibiting the problem behavior b. Other residents c. Staff's ability to perform treatment for resident with problem... 4. Identify desired behavior or change/ goals. 5. Establish interventions a. Educate staff in manner of approaching resident b. One - to -one visits/counseling c. Mental health evaluation / intervention d. Behavior programs -contracting -rewarding -redirection -reinforcement -group support -removal /relocation from problem situation		abuse. Resident #E's chart was fully reviewed to identify potential occurrences of verbal and/or physical abuse for further investigation and action as indicated. Measures to ensure this cited practice does not recur; April 6, 2011 Resident #E was placed on one-to-one monitoring until further notice. Social Service Director was re-educated to policy and procedure of Behavior Mgt, see (Attachment C) including identifying a resident's problem behavior including but not limited to Physical and/or verbal aggression. Identify precipitants to behavior including People involved, Environment, Verbal and Non-Verbal Behavior and using a log to track behaviors and precipitating factors, and educate staff in manner of approaching resident. Documentation of these findings on the Care Plan.Social Service Director was re-educated to the Social Service Job Description including discharge planning, development and implementation of the discharge plan, assisting with resident placement or relocation and notification of responsible party of discharge plan. Monitoring of corrective action; On April 6, 2011 Resident #E was placed on one-to-one monitoring until further notice and Social Services reviews the behavior log for resident 5x weekly and reports behavior events to the IDT during	

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	-family involvement -monitoring side effects of psychotropic medications -pastoral interventions 6. Document on Care Plan a. Problems b. Goals c. Approaches 7. Establish method of staffs recording / behavior logging of: a. Noted occurrence of problem behavior b. Interventions c. Results..." 2.) Review of the current undated facility policy, titled "Job Descriptions" ,provided by the Administrator on 4/5/11 at 1:30 p.m. indicated the following: Title: Social Service Director 1. Purpose The primary purpose of this job position is to assist the planning, organizing, developing and directing of Social Services in accordance with the current applicable federal and state standards, guidelines and regulations. In accordance		daily manager meeting. Findings will also be reported to the QA&A team on a weekly basis. (Attachment C) The Administrator is responsible as the facility abuse coordinator and has ultimate oversight in the discharge process and review of facility process and monitoring. The Social Service Director or designee will monitor behavior events to ensure physical and/or verbally aggressive or socially inappropriate or disruptive behaviors have appropriate action. (Attachment I) Social Service Director will monitor discharges to assure appropriate placement and family communication. (Attachment I) Social Service Director or designee will continue these monitors 5x weekly for 30 days, 3 times weekly for 30 days, and 1 x weekly for 90 days in total. Findings will be reported to the QA&A team on a weekly basis, and will become part of Randolph Nursing Homes Quality Assurance Program.	

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	with the policies and procedures of this facility, this position assures that the medically related emotional and social needs of the resident are met/ maintained on an individual basis... Major Duties and Responsibilities 1. Responsible for planning, developing, organizing, implementing, evaluating, and directing of the Social Service programs of this facility.... 6. Assess each resident's psychosocial needs and develop the plan for providing care... 7. Assist with discharge planning, development and implementation of the discharge plan and if appropriate arrange for community resources..." 3) .The clinical record for resident #E was reviewed on 4/3/11 at 4:30 p.m. Resident #E's current diagnoses included, but were not limited to, Huntington's disease, mood disorder and dementia with agitation. Nursing note entries from Resident #E's clinical record indicated the following,			

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	10/29/10 at 5:00 p.m., "resident has been verbally [sic] to other residents at table for meals. When tried to redirect resident resident became very hateful cursing at staff. Refused to leave dining room when finished instead continued to talk bad to tablemate. Social service made aware." 10/30/10 at 3:00 p.m., " Resident has been verbally taunting other residents at DR [dining room] table, saying "you're so ugly, I'd just shoot you", attempted to redirect resident. continues [with] behaviors." 10/31/10, at 3:00 p.m. "Continues [with] behaviors when @ [at] table in DR . called other resident gay, ugly and worthless, other resident did not respond back, attempted to redirect resident [without] success." 11/1/10 at 10:00 a.m., ..."very rude to other res [resident] during bkfst [breakfast], unable to redirect, refused to leave DR, calling other res "homo [homosexual], states res needs shot in head, "ugly"." 11/6/10 at 2:00 p.m., " Resident conts [continues] [with] behaviors during meals - calls tablemate ugly and states "they are going to shoot you" called him a macho man, other resident did not respond to			

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comments."

11/7/10 at 6 p.m., "Res has had cont [continued] behaviors at meal [times] called other res ugly - states he needs a gun to shoot other res - also tries to provoke other res to throw spill proof cup at said res, other res has not been initiating confrontation, unable to redirect."

11/8/10 at 1:00 p.m., ..."cont to be rude to other residents calling them "homos" stating they are ugly and need to be shot, resident undirectable, explained to res that behavior is unacceptable and he needs to leave the dining room, res refuses to leave or quit making comments..."

11/9/10 (no time) "cont [continues] [with] comments to other resident [Resident#39], undirectable."

11/10/10 at 10:00 a.m., "resident very verbally rude to [Resident #39] calling him a "homo" and saying res needs "shot in the head because he is so ugly" upon staff redirection res does not stop, just continues louder. Happens in dining room during meal time, removed [Resident #39] and bad mouthing continues."

11/11/10 at 10:00 a.m.. " Res conts to

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	make rude comments to [Resident #39], calls him "homo", "ugly" tells him he's not getting nothing..." 11/12/10 at 8:00 a.m." Resident conts to sit in dining room and make rude remarks to [Resident #39] calling res a "homo" and saying res is so ugly he needs to be shot unable to remove, redirect from dining room. Explained several x's [times] that behavior is unacceptable...." 11/13/10 at 3:00 p.m. "conts @ meals to make rude comments to resident [Resident#39]..." 11/17/10 at 9:00 a.m. resident continues to be disrespectful at mealtime to res [Resident #39] stating "you are an ugly homo, I should blow your head off" when trying to redirect res to stop being rude and disruptive res states "I know my rights" unable to redirect or get to remove self from table...' 11/25/10 at 9:30 a.m., "Resident very hateful [with] res [Resident #45]" in dining room this a.m. for breakfast yelling at res [Resident #45] to "sit down stupid if you were a human being you could comprehend..." 11/30/10 8:00 a.m. "Resident conts to be verbally hateful [with] other residents			

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	during breakfast, calling them "ugly" ..." 12/3/10 at 1:00 p.m. "Resident continues to be verbally rude to other residents when try to redirect res gets louder and more verbal, call other residents "homo, ugly and ignorant, says they need to be shot in the head ..." 12/6/10 (no time) "conts [with] verbal abuse towards other res, redirection unsuccessful..." 12/8/10 (no time) "conts [with] behaviors and rudeness towards other res calling res "homo" "ugly" states needs to be shot", flips said res off [with] middle finger, redirection unsuccessful..." 12/11/10 at 2:00 p.m. "continues to make rude gestures and yell to another resident at meal time..." 12/21/10 at 6:00 p.m., "during shift report CNA summoned writer to DR tablemate [Resident #29] was holding cheek stated that [Resident #E] had smacked her on the cheek, writer and on coming nurse tried to remove [Resident #E] from the table when res stood up and was cursing and yelling stating			

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	"I'm not going anywhere, I have my rights, res then hit other nurse and pushed writer, upon redirection offering to take res tray to room so he could finish and there res punched writer, finally removed from DR and taken to room." The clinical record indicated the Administrator and the resident's physician was called. The resident was placed on 15 minute checks to monitor behavior. The resident was transferred to an inpatient psychiatric unit at 8:30 p.m. on 12/21/10. The resident returned to the facility on 12/28/10. During an interview with the Social Services Designee on 4/5/11 at 4:30 p.m. she indicated she was unaware of the nursing note entries noted above. She further indicated she was unaware of any of the incidents of verbal abuse documented. She indicated she reviewed the "Behavior Sheets" daily and none of the documented behaviors of verbal abuse committed by Resident #E were recorded on a "Behavior Sheet." She indicated she had made no interventions with Resident #E's behavior planning because she was unaware of the incidents.			
SS=G	3. Resident #D's clinical record was reviewed on 4/4/11 at 2:50 p.m. The resident's diagnoses included, but were not limited to, Psychosis; mood disorder;		F 250 Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission	04/22/2011

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	vascular dementia; deaf and mute. The resident had a 3/2/11, telephone physician's order for Resident #D to be sent out to the emergency room for possible psychiatric placement. Review of a 3/3/11, Social Services Progress Note indicated resident was admitted to the psychiatric unit on 3/2/11. During an interview with the Discharge Planner at an in-patient Geri-Psych Unit on 4/6/11 at 8:00 a.m., she indicated she had updated the facility of Resident D's progress during his stay on the unit. She indicated she notified the facility the resident was stable and could return to the facility. She indicated the facility refused to readmit the resident and did not assist in finding a new placement for the resident. She indicated the resident's family had not been given a 30 day notice of discharge. During an interview with the Administrator and Social Service Designee on 4/5/11 at 3:50 p.m., they indicated they did not readmit the resident to the facility due to not being able to meet the resident's needs. They indicated the resident had been out to a psychiatric unit in February, 2011 and readmitted after that stay. They indicated the resident		or agreement by Randolph Nursing Home of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. **Please accept this plan of correction as our credible allegation of compliance with all regulatory requirements.** This facility provides medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident.Corrective action for affected residents Previously discharged residents C and D are residing at Parkview of Muncie. Residents #39 and Resident #45 were interviewed and each was without recollection of the event. Both families and physicians were notified of the subjected verbal abuse.On April 6, 2011 Resident #E was placed on one-to-one monitoring until further notice The Social Service Director was re-educated to Job Description including responsibility for planning, developing, organizing, implementing, evaluating and directing the Social Service programs. Assess each resident' s psychosocial needs and develop the plan of care. Assist with discharge planning, development and implementation of the discharge plan. Social Service Director was re-educated	

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	would become aggressive without provocation. The Social Service Designee indicated the resident was not meeting his Care Plan Goal of "I will not hit other people, if I become angry I will remove myself from the situation that is upsetting me." They indicated there was no documentation of a 30 day discharge notice being given to the family. During an interview with the resident's Power of Attorney on 4/6/11 at 8:20 a.m., she indicated she could not remember if she had been given a 30 day discharge notice or not. 4. Resident #C's clinical record was reviewed on 4/4/11 at 12:50 p.m. The resident's diagnoses included, but were not limited to, dementia with behavioral disturbances, personality disorders, and mood disorder. The resident had a 2/16/11, Physician's order for the resident to be transferred to the emergency room for a psychiatric evaluation and treatment. Review of a 2/16/11, Social Service Progress note indicated the resident transferred to an in-patient psychiatric unit due to an increase in unwarranted accusations towards staff members.		to policy and procedure of Behavior Mgt, including identifying a resident's problem behavior including but not limited to physical and/or verbal aggression. Identify precipitants to behavior including people involved, environment, verbal and non-verbal behavior and using a log to track behaviors and precipitating factors, and educate staff in manner of approaching resident. As well as, documentation updating the resident's Care Plan. (Attachment C)Identification of other residents at risk; Audit of discharged resident records was completed ensuring placement for the resident was found and appropriate communication to the responsible party. (Attachment I) Resident and staff interviews were completed to determine indication of other occurrences of potential verbal or physical abuse. Resident #E's chart was fully reviewed to identify potential occurrences of verbal and/or physical abuse for further investigation and action as indicated. Measures to ensure this cited practice does not recur; April 6, 2011 Resident #E was placed on one-to-one monitoring until further notice. Social Service Director was re-educated to policy and procedure of Behavior Mgt, see (Attachment C) including identifying a resident's problem behavior including but not limited	

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	During an interview with the Discharge Planner at an in-patient Geri-Psych Unit on 4/6/11 at 8:00 a.m., she indicated she had updated the facility of Resident C's progress during her stay on the unit. She indicated she notified the facility the resident was stable and could return to the facility. She indicated the facility refused to readmit the resident and did not assist in finding a new placement for the resident. During an interview with the Administrator and Social Service Designee on 4/5/11 at 3:50 p.m., they indicated they did not readmit the resident to the facility due to not being able to meet the resident's needs. They indicated the resident had been out to a psychiatric unit in December, 2010 and readmitted after that stay. They indicated the resident had increased behaviors of threatening the staff and making false accusations against the staff. They indicated they had not given a 30 day discharge notice to the family. This Federal tag relates to complaint #IN00087993 3.1-34(a)		to Physical and/or verbal aggression. Identify precipitants to behavior including People involved, Environment, Verbal and Non-Verbal Behavior and using a log to track behaviors and precipitating factors, and educate staff in manner of approaching resident. Documentation of these findings on the Care Plan.Social Service Director was re-educated to the Social Service Job Description including discharge planning, development and implementation of the discharge plan, assisting with resident placement or relocation and notification of responsible party of discharge plan. Monitoring of corrective action; On April 6, 2011 Resident #E was placed on one-to-one monitoring until further notice and Social Services reviews the behavior log for resident 5x weekly and reports behavior events to the IDT during daily manager meeting. Findings will also be reported to the QA&A team on a weekly basis. (Attachment C) The Administrator is responsible as the facility abuse coordinator and has ultimate oversight in the discharge process and review of facility process and monitoring. The Social Service Director or designee will monitor behavior events to ensure physical and/or verbally aggressive or socially inappropriate or disruptive behaviors have appropriate action. (Attachment I) Social	

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			Service Director will monitor discharges to assure appropriate placement and family communication. (Attachment I) Social Service Director or designee will continue these monitors 5x weekly for 30 days, 3 times weekly for 30 days, and 1 x weekly for 90 days in total. Findings will be reported to the QA&A team on a weekly basis, and will become part of Randolph Nursing Homes Quality Assurance Program.	
F0272	The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment			

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	protocols; and Documentation of participation in assessment.			
SS=D	Based on record review and interview, the facility failed to ensure residents identified at risk for constipation were assessed by the nursing staff in accordance with their plan of care in order to administer physician ordered interventions when necessary to prevent constipation for 2 of 11 residents reviewed for bowel monitoring in a sample of 16. (Resident #45 and #30) Findings include: 1.) The clinical record for Resident #45 was reviewed on 4/5/11 at 2:30 p.m. Diagnoses for Resident #45 included, but were not limited to, Alzheimer's disease with delusions. A Significant Change Minimum Data Set Assessment, dated 3/2/11, indicated Resident #45 had cognition impairment, was	F0272	F 272 Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by Randolph Nursing Home of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. **Please accept this plan of correction as our credible allegation of compliance with all regulatory requirements.** Assessments are conducted for each resident including bowel elimination.Corrective action for affected residents Residents #45 & # 30 have been assessed and care plans reviewed and revised as needed to assure monitoring of bowel movements and assessment and intervention as indicated for the prevention of constipation. Nursing education was provided to reinforce the necessity of monitoring and following the resident's care plan for promoting bowel function and preventing constipation. (Attachment C) Identification of other residents at risk; All residents are at risk of change in bowel function resulting less frequent bowel movement than every 3 days or frequency	04/22/2011

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	incontinent of bowel and bladder, and required the assistance of the staff for all activities of daily living. A health care plan problem, dated 11/18/09 and last reviewed on 3/16/11, indicated Resident #45 was at risk for constipation related to decreased mobility and use of antipsychotic medications. The goal for this problem was for the resident to have a soft formed stool every three days. Approaches for this problem included, but were not limited to, the following: "...3. Monitor and record BMs [bowel movements] 4. monitor BM flow sheet dly [daily] for need for laxative 5. If no BM in 3 days give MOM [milk of magnesia, a laxative] 30 cc [cubic centimeters] orally dly prn [when needed]. 6. Auccultate (sic) bowel sounds and assess for abdominal distention if residents is having pain or is unable to have BM... ...8. Colace (a stool softener) 100		designated by the resident's physician. To promote bowel function monitoring, assessment, and intervention as indicated, all nursing staff have been re-inserviced regarding, Nursing Standards which includes "All nursing staff assesses and evaluates the health status of the resident/client" and "Makes nursing judgments and decisions about their nursing care for the resident/client by using assessment data." (Attachment C)All residents Care Plans were reviewed and updated as needed by the DON or designee to ensure appropriate monitoring of bowel movement status, assessment and intervention needs are being met. The Director of Nursing or designee will review all residents bowel movement frequency and nursing intervention using form, by April 22, 2011 to assure nursing is assessing the clinical data, the plan of care, and the need for nursing assessment and/or intervention when needed. (Attachment H) Measures to ensure this cited practice does not recur; All nursing staff have been re-inserviced to Policy & Procedure for Bowel Elimination. (Attachment C) The Director of Nursing or her designee will review all resident charts to ensure the plan of care for each resident meets each resident's most current needs and will monitor to assure bowel	

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	mgs twice daily ...Dulcolax Supp [suppository]10 mg rectally prn ...Fleet enema 133 ml [milliliters] rectal prn" Bowel monitoring records for Resident #45 for the months of January, February, and March 2011, lacked documentation of the resident having a bowel movement during the following time periods: January 3, 4, 5, 6, 2011 February 11, 12, 13, 14, 15, 2011 March 17, 18, 19, 2011 The nursing notes and Medication Administration Records (MAR) for these time periods lacked documentation of any assessment of Resident #45 related to the lack of bowel movements. During an interview with the Director of Nursing and Administrator on 4/5/11 at 4:15 p.m., additional information was requested related to the lack of		movement frequency is monitored with interventions according to the care plan. (Attachment H) Monitoring of corrective action; The Director of Nursing or her designee will monitor to assure appropriate monitoring of resident BM frequency, and assessment and intervention according to resident' s individualized care plan. (Attachment H) Bowel Movement Monitor will be completed 5 x weekly for 30 days, 3 items weekly for 30 days, and 1 time weekly for 90 days in total. Monitoring results will be reported to facility administrator as completed and to the QA&A Team weekly, and will become part of Randolph Nursing Homes Quality Assurance Program.	

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	bowel assessments as noted above. During an interview on 4/6/11 at 11:00 a.m., the Director of Nursing indicated she had no information to provide related to the lack of bowel assessments noted above.			
SS=D	2.) The clinical record for Resident #30 was reviewed on 4/3/11 at 2:40 p.m. Diagnoses for Resident #30 included, but were not limited to, dementia with behaviors and agitation, depression, and constipation. A significant change Minimum Data Set (MDS) assessment, dated 2/24/11, indicated Resident #30 was cognitively impaired and dependent on the staff for toileting. A Health Care Plan problem, dated 9/29/10, indicated Resident #30 had a potential constipation. A goal for this problem was for the resident to have soft formed stool at least every 3 days with no undo strain.		F 272 Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by Randolph Nursing Home of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. **Please accept this plan of correction as our credible allegation of compliance with all regulatory requirements.** Assessments are conducted for each resident including bowel elimination.Corrective action for affected residents Residents #45 & # 30 have been assessed and care plans reviewed and revised as needed to assure monitoring of bowel movements and assessment and intervention as indicated for the prevention of constipation. Nursing education was provided to reinforce the necessity of monitoring and following the resident's care plan for promoting bowel function and	04/22/2011

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	Approaches included, but were not limited to, monitor and record all bowel movements every shift and use daily tracking form, and administer laxatives per physician's orders. Signed physician orders for resident, dated 2/7/11, included, but were not limited to, Docusate Sodium 100 mg, 2 times a day, Miralax, 17 Grams daily, and Milk of Magnesia, 30 ml daily as needed for constipation. Nurse's notes and Medication Administration Record (MAR) lacked any indication of bowel movement, assessment, and any needed medication interventions. During an interview with RN #7, on 4/5/11 at 8:40 a.m., nurse stated if interventions are performed they are documented on MAR and in nurse's notes. During an interview with the RN Consultant on 4/6/11 at 11 a.m., RN		preventing constipation. (Attachment C) Identification of other residents at risk; All residents are at risk of change in bowel function resulting less frequent bowel movement than every 3 days or frequency designated by the resident's physician. To promote bowel function monitoring, assessment, and intervention as indicated, all nursing staff have been re-inserviced regarding, Nursing Standards which includes "All nursing staff assesses and evaluates the health status of the resident/client" and "Makes nursing judgments and decisions about their nursing care for the resident/client by using assessment data." (Attachment C)All residents Care Plans were reviewed and updated as needed by the DON or designee to ensure appropriate monitoring of bowel movement status, assessment and intervention needs are being met. The Director of Nursing or designee will review all residents bowel movement frequency and nursing intervention using form, by April 22, 2011 to assure nursing is assessing the clinical data, the plan of care, and the need for nursing assessment and/or intervention when needed. (Attachment H) Measures to ensure this cited practice does not recur; All nursing staff have been re-inserviced to Policy & Procedure for Bowel Elimination.	

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	stated Care Tracker system, MAR and nurse's notes lacked any indication of bowel movements and interventions for Resident #30 for time periods of February 1-5, and 13-17. 3.) Review of a current facility policy dated 2003, provided by Administrator on 4/5/11 at 1:30 p.m., titled "BOWEL ELIMINATION", included, but was not limited to, the following: "POLICY: It is the policy of this facility to manage constipation by using intervention guidelines designed to prevent and treat constipation in		(Attachment C) The Director of Nursing or her designee will review all resident charts to ensure the plan of care for each resident meets each resident's most current needs and will monitor to assure bowel movement frequency is monitored with interventions according to the care plan. (Attachment H) Monitoring of corrective action; The Director of Nursing or her designee will monitor to assure appropriate monitoring of resident BM frequency, and assessment and intervention according to resident' s individualized care plan. (Attachment H) Bowel Movement Monitor will be completed 5 x weekly for 30 days, 3 items weekly for 30 days, and 1 time weekly for 90 days in total. Monitoring results will be reported to facility administrator as completed and to the QA&A Team weekly, and will become part of Randolph Nursing Homes Quality Assurance Program.	

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	155231	A. BUILDING 00 B. WING	04/06/2011

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	our residents. INTENT: The purpose is to reduce the frequency and severity of constipation. The goal to maintain normal bowel movements per the individual's bowel frequency with straining at stool less than 25%. PROCEDURE 1. Assess for risk of constipation and elimination habits on admission using an assessment inventory (see assessment inventory). 2. Complete bowel function diary for each resident requiring management of constipation (see bowel function diary).... ...3. Intestinal elimination is to be closely on all residents. Nurse aides will record in the elimination record all bowel movements. 4. Each night the charge nurse will			

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	list all residents who have not eliminated in 1 day, 2 days, and 3 days. The day and evening charge nurse then will assess the needs for laxatives and enemas and treat appropriately...." 3.1-31(a)			
F0279	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			
SS=D	Based on record review and interview, the facility failed to ensure each resident had a comprehensive health care plan	F0279	F279 Preparation and/or execution of this plan of correction in general, or this corrective action in particular,	04/22/2011

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	developed to address the needs of the resident for 2 of 13 residents reviewed for the development of comprehensive health care plans in a sample of 16. (Resident #70 and #72) Findings include: 1.) The clinical record for Resident #70 was reviewed on 4/3/11 at 4:00 p.m. Diagnoses for Resident #70 included, but were not limited to, history of aspiration pneumonia, chronic respiratory failure with status post tracheostomy, paraplegia, and diabetes mellitus. The clinical record indicated the resident received nutrition via a gastrostomy tube, had an anchored catheter, and had a colostomy. Admission orders, dated 3/25/11, indicated resident #70 was to receive humidification at 28% via tracheostomy (trach) and be given trach care every shift. An admission Minimum Data Set Assessment, dated 4/1/11, indicated Resident #70 was totally dependent on the staff for all activities of daily living and had a tracheostomy. A nursing note, dated 3/27/11 at 1:00 p.m., indicated Resident #70's lungs were clear and no signs and symptoms of		does not constitute an admission or agreement by Randolph Nursing Home of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. **Please accept this plan of correction as our credible allegation of compliance with all regulatory requirements.** Individualized Care Plans are developed for each resident to address the needs of the resident. Corrective action for affected residents Upon return from the hospital resident #70 will be assessed relating to his diagnosis of chronic respiratory failure with status post tracheostomy and possible respiratory complications for which resident #70 should be monitored and the physician notified if indicated.Resident #72 care plan has been updated to include toileting needs, monitoring of bowel patterns for possible constipation and need for administration of medications as ordered by the physician. See (Attachment B).Identification of other residents at risk; All nursing staff will be re-inserviced (as of April 22, 2011) regarding facility P&P on Care Planning which will includes; addressing the needs of the resident in the individualized resident care with measureable goals. (Attachment C) All	

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	infection were noted. The note indicated the resident's temperature was within normal limits. A nursing note, dated 3/28/11 at 7:35 p.m., indicated "... lungs with coarse crackles, productive cough noted at times, trach care given... small amount of thick yellow sputum noted...." A nursing note, dated 3/29/11 at 8:40 p.m., indicated "...lungs with bilateral crackles... suctioned times 3 this shift with large amounts of thick yellow sputum, inner canula changed times 2..." A nursing note, dated 3/30/11 at 4:00 p.m., indicated the resident had developed a temperature of 101.3 (type of temperature not noted) and Tylenol had been given. The note indicated "...lungs crackles in lower lobes...." A follow-up note at 8:00 p.m. indicated the resident's temperature was now 100.9 and Tylenol was given. The clinical record lacked any information related to the physician being notified of the residents yellow sputum and elevated temperature. The current health care plans for Resident #70, dated 3/25/11 and 3/30/11, lacked any comprehensive health care planning		residents Plan of Care will be reviewed to ensure the monitoring of bowel patterns for possible constipation and need for administration of medications as ordered by the physician. (Attachment D)All residents Plan of Care will be reviewed to ensure those residents, identified with chronic respiratory failure and related complications, have a comprehensive health care plan which will include post tracheostomy care and possible respiratory complications for which the resident should be monitored and the physician notified if indicated. (Attachment E)Measures to ensure this deficient practice does not recur; All nursing staff will be re-inserviced (as of April 22, 2011) regarding facility P&P on Care Planning which will include; Problems must be specifically care planned; All goals bust be measurable. (attachment C). Monitoring of corrective action; Upon return to the facility the individualized care plan for resident #72 will be reviewed by the DON and revised to address the needs of the resident including but not limited to chronic respiratory failure with post tracheostomy and treatments or monitoring indicated for this resident. The IDT will review resident # 72's care plan to assure inclusion of pertinent information. The Director of Nursing or her designee will	

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	related to the resident's diagnosis of chronic respiratory failure with status post tracheostomy requiring the need for humidification at 28%, frequent nebulizer treatments, tracheostomy care twice daily, and possible respiratory complications for which the resident should be monitored and the physician notified if indicated. During an interview with the Director of Nursing and Administrator on 4/4/11 at 4:00 p.m., additional information was requested related to the lack of development of a comprehensive plan of care related to the resident's chronic respiratory failure and tracheostomy. The facility failed to provide any additional information as of exit on 4/6/11. 2.) The clinical record for Resident #72 was reviewed on 4/4/11 at 3:30 p.m. Diagnoses for Resident #72 included, but were not limited to, Huntington's Disease with		complete random chart audits to assure appropriate comprehensive care plan development addressing the needs of the resident including risk of constipation and risk of chronic respiratory failure post tracheostomy as applicable. (Attachment D & E) Five charts, 5 x weekly for 30 days, 3 x weekly for 30 days, 1 time weekly for 90 days in total. Findings will be reported to the Administrator and QA&A team on a weekly basis, and will become part of Randolph Nursing Homes Quality Assurance Program.	

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	dementia, aphasia and dysphasia. A quarterly Minimum Data Set (MDS)Assessment, dated 1/13/11, indicated Resident #72 rarely made decisions, was incontinent of bladder and bowel, and required the assistance of the staff for all activities of daily living. A physician's progress note, dated 12/31/11, indicated "...3. Constipation - start reg [regular] meds [medications]." Current physician's orders for Resident #72 included, but were not limited to, Bisacodyl (a laxative) 5 milligrams (mgs) one tablet every morning routinely and Bisacodyl 10 mg suppository one rectally every 2 days as needed. The original date of these orders was 1/1/11. A Health Care Plan problem, dated 3/29/11, indicated Resident #72 had Huntington's disease and was dependent on the staff to meet his needs. The problem indicated			

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	Resident #72 was at risk for multiple problems including, but not limited to, constipation. The only goal for this problem was "I will be clean and neat in my appearance." The approaches for this problem lacked any information related to the need to assist Resident #72 with toileting, monitor his bowel pattern for possible constipation, administer his daily laxative medication, and administer the Bisacodyl suppository if needed as ordered by the physician for constipation. During an interview with the Director of Nursing, MDS Coordinator, and Administrator on 4/5/11 at 11:15 a.m., additional information was requested related to the lack of a comprehensive health care plan having been developed for Resident #72 related to bowel and constipation concerns. The MDS Coordinator indicated the facility was in the process of			

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	changing to the "I" format for health care planning which combined multiple areas and Resident #72's health care plan had been completed in this format. The facility failed to provide any additional information as of exit on 4/6/11.			
SS=D	3.) Review of a current facility policy dated 2003, provided by Admin on 4/5/11 at 1:30 p.m., titled "CARE PLANNING", included, but was not limited to, the following: "POLICY: Interdisciplinary Health Care Plan meetings are scheduled routinely and after a		F279 Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by Randolph Nursing Home of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. **Please accept this plan of correction as our credible allegation of compliance with all regulatory requirements.** Individualized Care Plans are developed for each resident to address the needs of the resident. Corrective action for affected residents Upon return from the hospital resident #70 will be assessed relating to his diagnosis of chronic respiratory failure with status post tracheostomy and possible respiratory complications for	04/22/2011

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	significant change in a resident's condition to enable the staff, family and residents to develop an interdisciplinary plan that would allow the resident to reach his/her highest level of mental, physical, spiritual and psychosocial well-being.... ...CARE PLANNING: All problems identified must be specifically care planned, including individualized nursing measures to be carried out to the execute the plan. If you are having difficulty with deciding what the problem is, consider why		which resident #70 should be monitored and the physician notified if indicated.Resident #72 care plan has been updated to include toileting needs, monitoring of bowel patterns for possible constipation and need for administration of medications as ordered by the physician. See (Attachment B).Identification of other residents at risk; All nursing staff will be re-inserviced (as of April 22, 2011) regarding facility P&P on Care Planning which will includes; addressing the needs of the resident in the individualized resident care with measureable goals. (Attachment C) All residents Plan of Care will be reviewed to ensure the monitoring of bowel patterns for possible constipation and need for administration of medications as ordered by the physician. (Attachment D)All residents Plan of Care will be reviewed to ensure those residents, identified with chronic respiratory failure and related complications, have a comprehensive health care plan which will include post tracheostomy care and possible respiratory complications for which the resident should be monitored and the physician notified if indicated. (Attachment E)Measures to ensure this deficient practice does not recur; All nursing staff will be re-inserviced (as of April 22, 2011) regarding facility P&P on Care Planning which will include;	

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	the restorative measures are necessary. This should guide you to the problem or needs. All goals must be measurable and interventions need to be care planned and match the interventions being carried out by staff. One-to-one activities must be specifically planned and show who will be doing what with a resident and when. Areas to initially address are: a. Psychosocial well being b. Mood/behavior		Problems must be specifically care planned; All goals bust be measurable. (attachment C). Monitoring of corrective action; Upon return to the facility the individualized care plan for resident #72 will be reviewed by the DON and revised to address the needs of the resident including but not limited to chronic respiratory failure with post tracheostomy and treatments or monitoring indicated for this resident. The IDT will review resident # 72's care plan to assure inclusion of pertinent information. The Director of Nursing or her designee will complete random chart audits to assure appropriate comprehensive care plan development addressing the needs of the resident including risk of constipation and risk of chronic respiratory failure post tracheostomy as applicable. (Attachment D & E) Five charts, 5 x weekly for 30 days, 3 x weekly for 30 days, 1 time weekly for 90 days in total. Findings will be reported to the Administrator and QA&A team on a weekly basis, and will become part of Randolph Nursing Homes Quality Assurance Program.	

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	c. Communication abilities and motivation d. Sensory impairments e. Cognitive functioning f. Customary routine of resident g. Psychoactive medications h. Physical restraints i. Discharge planning..." resident. Staff members showing any trend toward impatience or frustration in routine dealings with residents should be evaluated for possible temporary assignment or unpaid leave of absence ...."			

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	3.1-35(a)			
F0309	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.			
SS=D	Based on record review and interview, the facility failed to ensure residents identified at risk for constipation had their bowels monitored in order to administer physician ordered interventions when necessary to prevent constipation for 2 of 11 residents reviewed for bowel monitoring in a sample of 16. (Resident #45 and #30) Findings include: 1.) The clinical record for Resident #45 was reviewed on 4/5/11 at 2:30 p.m. Diagnoses for Resident #45 included, but were not limited to, Alzheimer's disease with delusions.	F0309	F 309Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by Randolph Nursing Home of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. **Please accept this plan of correction as our credible allegation of compliance with all regulatory requirements.** Corrective action for affected residents Resident #45 & resident #30 have been assessed for active bowel sounds. All nursing staff has been re-inserviced to Policy & Procedure for Bowel Elimination. (Attachment C) Identification of other residents at risk; All nursing staff have been re-inserviced to Policy & Procedure for Bowel Elimination. (Attachment C) The Director of Nursing or her designee will review all resident charts to	04/22/2011

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	A Significant Change Minimum Data Set Assessment, dated 3/2/11, indicated Resident #45 had cognition impairment, was incontinent of bowel and bladder, and required the assistance of the staff for all activities of daily living. A health care plan problem, dated 11/18/09 and last reviewed on 3/16/11, indicated Resident #45 was at risk for constipation related to decreased mobility and use of antipsychotic medications. The goal for this problem was for the resident to have a soft formed stool every three days. Approaches for this problem included, but were not limited to, the following: "...3. Monitor and record BMs [bowel movements] 4. monitor BM flow sheet dly [daily] for need for laxative 5. If no BM in 3 days give MOM [milk of magnesia, a laxative] 30 cc [cubic centimeters] orally dly prn [when needed].		ensure the plan of care for each resident meets each residents most current needs and intervention are being followed according to the care plan. (Attachment H) Measures to ensure this deficient practice does not recur; All nursing staff have been re-inserviced to Policy & Procedure for Bowel Elimination. (Attachment C) The Director of Nursing or her designee will review all resident charts to ensure the plan of care for each resident meets each resident's most current needs and will monitor to assure interventions are being followed according to the care plan. (Attachment H) Monitoring of corrective action; The Director of Nursing or her designee will monitor to assure appropriate monitoring of resident BM frequency, and assessment and intervention. (Attachment H) Monitoring be the DON or designee will be completed 5 x weekly for 30 days, 3 items weekly for 30 days, and 1 time weekly for 90 days in total. Monitoring results will be reported to the QA&A Team weekly, and will become part of Randolph Nursing Homes Quality Assurance Program.	

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	6. Auccultate (sic) bowel sounds and assess for abdominal distention if residents is having pain or is unable to have BM... ...8. Colace (a stool softener) 100 mgs twice daily ...Dulcolax Supp [suppository]10 mg rectally prn ...Fleet enema 133 ml [milliliters] rectal prn" A recapitulation of physician's orders, dated 3/2/11, indicated Resident #45 had the following bowel related orders which all had an original start date of 6/10/10: Dulcolax supp 10 mg one rectally as needed for constipation Fleet enema 133 mls rectally as directed prn for constipation Milk of Magnesia 30 cc as needed if no BM in 3 days Colace 100 mg twice daily Bowel monitoring records for Resident #45 for the months of January, February, and March 2011, lacked documentation of the			

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	resident having a bowel movement during the following time periods: January 3, 4, 5, 6, 2011 February 11, 12, 13, 14, 15, 2011 March 17, 18, 19, 2011 The nursing notes and Medication Administration Records (MAR) for these time periods lacked documentation of any assessment of Resident #45 related to the lack of bowel movements or any information related to the physician ordered interventions having been given. During an interview with the Director of Nursing and Administrator on 4/5/11 at 4:15 p.m., additional information was requested related to the lack of bowel movements noted above. During an interview on 4/6/11 at 11:00 a.m., the Director of Nursing indicated she had no information to provide related to the lack of bowel movements noted above.			

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SS=D	3.) The clinical record for Resident #30 was reviewed on 4/3/11 at 2:40 p.m. Diagnoses for Resident #30 included, but were not limited to, dementia with behaviors and agitation, depression, and constipation. A significant change Minimum Data Set (MDS) assessment, dated 2/24/11, indicated Resident #30 was cognitively impaired and dependent on the staff for toileting. A Health Care Plan problem, dated 9/29/10, indicated Resident #30 had a potential constipation. A goal for this problem was for the resident to have soft formed stool at least every 3 days with no undo strain. Approaches included, but were not limited to, monitor and record all bowel movements every shift and		F 309Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by Randolph Nursing Home of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. **Please accept this plan of correction as our credible allegation of compliance with all regulatory requirements.** Corrective action for affected residents Resident #45 & resident #30 have been assessed for active bowel sounds. All nursing staff has been re-inserviced to Policy & Procedure for Bowel Elimination. (Attachment C) Identification of other residents at risk; All nursing staff have been re-inserviced to Policy & Procedure for Bowel Elimination. (Attachment C) The Director of Nursing or her designee will review all resident charts to ensure the plan of care for each resident meets each residents most current needs and intervention are being followed	04/22/2011

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	use daily tracking form, and administer laxatives per physician's orders. Signed physician orders for resident, dated 2/7/11, included, but were not limited to, Docusate Sodium 100 mg, 2 times a day, Miralax, 17 Grams daily, and Milk of Magnesia, 30 ml daily as needed for constipation. Nurse's notes and Medication Administration Record (MAR) lacked any indication of bowel movement, assessment, and any needed medication interventions. During an interview with RN #7, on 4/5/11 at 8:40 a.m., nurse stated if interventions are performed they are documented on MAR and in nurse's notes. During an interview with the RN Consultant on 4/6/11 at 11 a.m., RN stated Care Tracker system, MAR and nurse's		according to the care plan. (Attachment H) Measures to ensure this deficient practice does not recur; All nursing staff have been re-inserviced to Policy & Procedure for Bowel Elimination. (Attachment C) The Director of Nursing or her designee will review all resident charts to ensure the plan of care for each resident meets each resident's most current needs and will monitor to assure interventions are being followed according to the care plan. (Attachment H) Monitoring of corrective action; The Director of Nursing or her designee will monitor to assure appropriate monitoring of resident BM frequency, and assessment and intervention. (Attachment H) Monitoring be the DON or designee will be completed 5 x weekly for 30 days, 3 items weekly for 30 days, and 1 time weekly for 90 days in total. Monitoring results will be reported to the QA&A Team weekly, and will become part of Randolph Nursing Homes Quality Assurance Program.	

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notes lacked any indication of bowel movements and interventions for Resident #30 for time periods of February 1-5, and 13-17.

4.) Review of a current facility policy dated 2003, provided by Admin on 4/5/11 at 1:30 p.m., titled "BOWEL ELIMINATION", included, but was not limited to, the following:

"POLICY:

It is the policy of this facility to manage constipation by using intervention guidelines designed to prevent and treat constipation in our residents.

INTENT:

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	The purpose is to reduce the frequency and severity of constipation. The goal to maintain normal bowel movements per the individual's bowel frequency with straining at stool less than 25%. PROCEDURE 1. Assess for risk of constipation and elimination habits on admission using an assessment inventory (see assessment inventory). 2. Complete bowel function diary for each resident requiring management of constipation (see bowel function diary).... ...3. Intestinal elimination is to be closely on all residents. Nurse aides will record in the elimination record all bowel movements. 4. Each night the charge nurse will list all residents who have not eliminated in 1 day, 2 days, and 3 days. The day and evening charge nurse then will assess the needs for			

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	laxatives and enemas and treat appropriately...." 3.1-37(a)			
F0365 SS=D	Each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on record review, observation, and interview, the facility failed to ensure a resident received thickened liquids as ordered by the physician to prevent possible swallowing problems and/or aspiration for 1 of 3 residents reviewed with orders for thickened liquids in a sample of 16. (Resident #72) Findings include: 1.) The clinical record for Resident #72 was reviewed on 4/4/11 at 3:30 p.m. Diagnoses for Resident #72 included, but were not limited to, Huntington's Disease with	F0365	F365 Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by Randolph Nursing Home of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. **Please accept this plan of correction as our credible allegation of compliance with all regulatory requirements.** Food is prepared in a form to meet the individual needs. Corrective action for affected resident; Dietary and Nursing Staff have been re-educated to following tray cards provided for each resident meal tray including appropriate consistency and serving method for pudding thick liquids. (Attachment C.) FSD or designee monitors to assure Resident #72 receives his meal tray fluids in appropriate	04/22/2011

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	dementia, aphasia and dysphasia. A physician's order, dated 1/7/11 indicated resident #72 was to receive a pureed diet with pudding thick liquids. A quarterly Minimum Data Set Assessment, dated 1/13/11, indicated Resident #72 rarely made decisions, received a mechanically altered diet, and required the assistance of the staff for all activities of daily living. A Health Care Plan problem, dated 3/29/11, indicated Resident #72 had problems with a protruding tongue causing him to drool on his self and was at risk for choking and aspirating when consuming food and drinks. Approaches for this problem included, but were not limited to, "I will be fed by staff my pureed diet with pudding thick liquids...." During an observation on 4/3/11 at 5:35 p.m., Resident #72 was up in		consistency and delivery device as ordered by physician. Identification of other residents at risk; All residents with thickened liquid diet orders are at risk. Resident Diet tray cards were reviewed April 22, 2011 by the FSS or her designee to ensure meals served are following meal slips provided for each resident meal tray. Dietary and Nursing Staff have been inserviced to Policies & Procedures Tray I.D. Cards to ensure each tray properly identifies each resident's needs and including appropriate consistency and serving method for pudding thick liquids. Measures to ensure this deficient practice does not recur; Dietary and Nursing Staff have been inserviced to Policies & Procedures and Tray I.D. Cards to ensure each tray properly identifies each resident's needs, including appropriate consistency and serving method for pudding thick liquids. (Attachment C) Resident Diet tray cards were be reviewed by the FSS or her designee April ,2011 and ongoing monitoring will continue to ensure meals served are following meal slips provided for each resident meal tray including appropriate consistency and serving method for pudding thick liquids. Monitoring will be completed5x weekly for 30 days, 3 times weekly for 30 days, 1 time weekly for 90 days in total. (Attachment G) Monitoring	

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	his reclining geri chair in the small dining room by the 300 hall nursing station. The staff had served his tray and was preparing to feed him. The meal slip on the resident's tray indicated the resident was to receive a pureed diet with pudding thick liquids. A large sippy-cup had been sent from the kitchen and was with the resident's tray. The resident had a pureed diet and a large glass of of tomato juice. The tomato juice was in regular form and had not been thickened. CNA #4 indicated Resident #72 did not like tomatoes and asked CNA #3 to get him some chocolate milk. CNA #3 returned with the chocolate milk and gave it to CNA #4 who was preparing to pour it into the sippy cup. When queried regarding the use of a sippy cup with pudding thick liquids, CNA #3 and CNA # 4 indicated they always used a sippy cup for resident #72 and were unaware the resident's liquids were to be thickened.		of corrective action; The FSS or her designee will monitor Diet tray cards to ensure meals served are following meal slips provided for each resident meal tray including appropriate consistency and serving method for pudding thick liquids. (Attachment G) Monitoring will be completed during Breakfast, Lunch or Supper, at least 5x weekly for 30 days, 3 times weekly for 30 days, 1 time weekly for 90 days in total. Findings will be reported to the QA&A team weekly, and will become part of Randolph Nursing Homes Quality Assurance Program.	

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	LPN #2 was sitting nearby and told the CNAs that pudding thick liquids could not be given through a sippy cup and instructed them to obtain some thickener and thicken the chocolate milk to pudding thick consistency. CNA #3 went to the nursing station area, obtained a container of powdered thickener, and thickened the chocolate milk to pudding thick consistency. The resident consumed the entire serving of pudding thick chocolate milk.			
SS=D	2.) Review of a current facility policy, dated 2003, provided by the DoN on 4/4/11 at 4:35 p.m., titled "THICKENED LIQUIDS", included, but was not limited to, the following:		F365 Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by Randolph Nursing Home of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. **Please accept this plan of correction as our credible allegation of compliance with all regulatory requirements.** Food is prepared in a form to meet the individual needs. Corrective action for affected	04/22/2011

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	"PURPOSE: To optimize the therapeutic benefit of commercial thickeners for swallowing disorders and to assure the residents with orders for such thickeners are receiving consistent and appropriate treatment according to physician order...." 3.1-21(a)(3)		resident; Dietary and Nursing Staff have been re-educated to following tray cards provided for each resident meal tray including appropriate consistency and serving method for pudding thick liquids. (Attachment C.) FSD or designee monitors to assure Resident #72 receives his meal tray fluids in appropriate consistency and delivery device as ordered by physician. Identification of other residents at risk; All residents with thickened liquid diet orders are at risk. Resident Diet tray cards were reviewed April 22, 2011 by the FSS or her designee to ensure meals served are following meal slips provided for each resident meal tray. Dietary and Nursing Staff have been inserviced to Policies & Procedures Tray I.D. Cards to ensure each tray properly identifies each resident's needs and including appropriate consistency and serving method for pudding thick liquids. Measures to ensure this deficient practice does not recur; Dietary and Nursing Staff have been inserviced to Policies & Procedures and Tray I.D. Cards to ensure each tray properly identifies each resident's needs, including appropriate consistency and serving method for pudding thick liquids. (Attachment C) Resident Diet tray cards were be reviewed by the FSS or her designee April ,2011 and ongoing monitoring will continue to	

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			ensure meals served are following meal slips provided for each resident meal tray including appropriate consistency and serving method for pudding thick liquids. Monitoring will be completed5x weekly for 30 days, 3 times weekly for 30 days, 1 time weekly for 90 days in total. (Attachment G) Monitoring of corrective action; The FSS or her designee will monitor Diet tray cards to ensure meals served are following meal slips provided for each resident meal tray including appropriate consistency and serving method for pudding thick liquids. (Attachment G) Monitoring will be completed during Breakfast, Lunch or Supper, at least 5x weekly for 30 days, 3 times weekly for 30 days, 1 time weekly for 90 days in total. Findings will be reported to the QA&A team weekly, and will become part of Randolph Nursing Homes Quality Assurance Program.	